# 2026 Employee
## Annual Compliance Notices

FOREST RIVER

# Compliance Notices



**The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.**

**If you have any questions regarding any of these notices, please contact:**

**General Contact: David Besinger**

**Phone: 574-367-3268**

**Email: dbesinger@forestriverinc.com**

**Mailing Address: 900 County Road, PO Box 3030**

**Elkhart, IN 46515**

**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 14 for more details.**


| | |
|---|---|
| Exchange/Marketplace Notice | Pg. 3 |
| Summary of Benefits and Coverage: $1250 Plan | Pg. 6 |
| Summary of Benefits and Coverage: $5000 Plan | Pg. 13 |
| Notice of Special Enrollment Rights | Pg. 20 |
| Notice of Patient Protection | Pg. 20 |
| Women's Health and Cancer Rights Act Notice | Pg. 20 |
| Newborns and Mothers Health Protection Act | Pg. 20 |
| Michelle's Law Notice | Pg. 21 |
| HIPAA Notice of Privacy Practices | Pg. 21 |
| Genetic Information Nondiscrimination Act Notice | Pg. 21 |
| Mental Health Parity Act Notice | Pg. 21 |
| Qualified Medical Child Support Order Notice | Pg. 22 |
| Uniformed Services Employment and Reemployment Rights Act | Pg. 22 |
| CHIP Notice | Pg. 23 |
| Surprise Medical Billing Notice | Pg. 27 |
| Medicare Part D Notice | Pg. 28 |
| Summary Annual Report | Pg. 30 |

# Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

## PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

## What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

## Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

## Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1]

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

---

[1]Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2]An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

# Compliance Notices



## When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

## What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

## How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your human resources department. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

# Compliance Notices



## PART B: Information About Health Coverage Offered by Your Employer

| | | |
|---|---|---|
| 3. Employer Name<br><br>Forest River, Inc. | | 4. Employer Identification Number (EIN)<br><br>20-3284366 |
| 5. Employer address<br><br>900 County Road 1, PO Box 3030 | | 6. Employer phone number<br><br>574-389-4600 |
| 7. City<br><br>Elkhart | 8. State<br><br>IN | 9. ZIP code<br><br>46515 |
| 10. Who can we contact about employee health coverage at this job?<br><br>David Besinger | | |
| 11. Phone number (if different from above)<br><br>574-367-3268 | | 12. Email address<br><br>dbesinger@forestriverinc.com |

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All Employees. Eligible employees are:

☒ All employees, who are eligible employees, shall be covered on the day they become eligible, as discussed in the Key Information section of this document

Some employees. Eligible employees are:

☐

With respect to dependents:

We do offer coverage. Eligible dependents are:

☒ Dependents shall be covered simultaneously with employees covering them as dependents. Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the employee will begin from the date of Placement for Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of "dependent". With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 30 days from date of marriage.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-312-906-8080 or go to www.alliedbenefit.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. www.alliedbenefit.com or call 1-312-906-8080 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers $1,250 person / $2,500 family; for out- of-network providers $3,000 person / $6,000 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes, in-network preventive care, in-network physician exam charges (including specialists), in-network urgent care exam charges, second surgical opinions, in-network physical/occupational/speech therapy office visits, in-network chiropractic care, and Organ or Tissue Transplant Procedures at a Blue Distinction Center facility or Anthem Center of Medical Excellence are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $100 person / $200 family for prescription drug coverage. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Medical:<br>For in-network providers $4,000 person / $8,000 family; for out-of-network providers $10,000 person / $20,000 family<br>Prescription Drugs:<br>$2,500 person / $5,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.alliedbenefit.com or call 1-312-906-8080 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/visit, deductible does not apply; $40 copay/chiropractic care, deductible does not apply | 40% coinsurance | Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. See Plan Document for other services. |
| | Specialist visit | $45 copay/visit, deductible does not apply | 40% coinsurance | See Plan Document for other services. |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance for Independent Laboratory; 20% coinsurance for outpatient services | 40% coinsurance | Does not include emergency room or urgent care diagnostic services. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.cap-rx.com | Generic drugs (Tier 1) | 10% up to a maximum copay of $20 / prescription (retail) $25 copay/prescription (extended retail and mail-order) | | Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). Rx Deductible does apply. Once the Prescription Drug out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year. |
| | Preferred brand drugs (Tier 2) | 20% up to a maximum copay of $50 / prescription (retail) $50 copay/prescription (extended retail and mail-order) | | |
| | Non-preferred brand drugs (Tier 3) | 30% up to a maximum copay of $150 / prescription (retail) $150 copay/prescription (extended retail and mail-order) | | |
| | Specialty drugs (Tier 4) | 40% up to a maximum copay of $200 per prescription | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance for ambulatory surgery center; 20% coinsurance for outpatient hospital facility | 40% coinsurance | Preauthorization is required for certain services. Those services must be pre-certified in order to avoid $250 penalty per occurrence. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None. |
| **If you need immediate medical attention** | Emergency room care | $450 copay/visit, then 20% coinsurance | | None. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Urgent care | $30 copay/visit, deductible does not apply | 40% coinsurance | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay, deductible does not apply, for office visit; 20% coinsurance for other outpatient services | 40% coinsurance | Preauthorization is required for certain services. Those services must be pre-certified in order to avoid $250 penalty per occurrence. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Office visits | $20 copay/visit, deductible does not apply | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid $250 penalty. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Limited to 60 visits per person per calendar year. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Rehabilitation services | $40 copay, deductible does not apply, for office visit; 20% coinsurance for other outpatient services | 40% coinsurance | None. |
| | Habilitation services | $40 copay, deductible does not apply, for office visit; 20% coinsurance for other outpatient services | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Limited to 60 days per person per calendar year. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | None. |
| | Hospice services | 20% coinsurance | 40% coinsurance | None. |
| **If your child needs dental or eye care** | Children's eye exam | No charge, deductible does not apply | Not covered | Applies from birth through age 5. |
| | Children's glasses | Not covered | Not covered | Not covered. |
| | Children's dental check-up | Not covered | Not covered | Not covered. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic Care
- Infertility treatment (except promotion of conception)
- Weight Loss Programs (nonsurgical obesity treatment)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator at (574) 389-4600 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage? Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$1,250** |
| **Specialist copayment** | **$45** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,300 |
| Copayments | $0 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,560** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$1,250** |
| **Specialist copayment** | **$45** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles* | $1,000 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,020** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$1,250** |
| **Specialist copayment** | **$45** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles* | $1,200 |
| Copayments | $700 |
| Coinsurance | $80 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,980** |

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-312-906-8080 or go to www.alliedbenefit.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. www.alliedbenefit.com or call 1-312-906-8080 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers $5,000 person / $10,000 family; for out- of-network providers $10,000 person / $20,000 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes, in-network preventive care, in-network physician exam charges (including specialists), in-network urgent care exam charges, second surgical opinions, in-network physical/occupational/speech therapy office visits, in-network chiropractic care, and Organ or Tissue Transplant Procedures at a Blue Distinction Center facility or Anthem Center of Medical Excellence are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $250 person / $500 family for prescription drug coverage. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Medical:<br>For in-network providers $6,500 person / $13,000 family; for out-of-network providers $13,000 person / $26,000 family<br>Prescription Drugs:<br>$2,500 person / $5,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.alliedbenefit.com or call 1-312-906-8080 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $40 copay/visit, deductible does not apply; $50 copay/chiropractic care, deductible does not apply | 40% coinsurance | Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants, and mental health providers. See Plan Document for other services. |
| | Specialist visit | $60 copay/visit, deductible does not apply | 40% coinsurance | See Plan Document for other services. |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance for Independent Laboratory; 20% coinsurance for outpatient services | 40% coinsurance | Does not include emergency room or urgent care diagnostic services. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.cap-rx.com | Generic drugs (Tier 1) | 10% up to a maximum copay of $40 / prescription (retail) $40 copay/prescription (extended retail and mail-order) | | Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). Rx Deductible does apply. Once the Prescription Drug out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year. |
| | Preferred brand drugs (Tier 2) | 20% up to a maximum copay of $100 / prescription (retail) $100 copay/prescription (extended retail and mail-order) | | |
| | Non-preferred brand drugs (Tier 3) | 30% up to a maximum copay of $300 / prescription (retail) $300 copay/prescription (extended retail and mail-order) | | |
| | Specialty drugs (Tier 4) | 40% up to a maximum copay of $400 per prescription | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance for ambulatory surgery center; 20% coinsurance for outpatient hospital facility | 40% coinsurance | Preauthorization is required for certain services. Those services must be pre-certified in order to avoid $250 penalty per occurrence. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None. |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | | None. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Urgent care | $50 copay/visit, deductible does not apply | 40% coinsurance | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 copay, deductible does not apply, for office visit; 20% coinsurance for other outpatient services | 40% coinsurance | Preauthorization is required for certain services. Those services must be pre-certified in order to avoid $250 penalty per occurrence. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Office visits | $40 copay/visit, deductible does not apply | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid $250 penalty. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Limited to 60 visits per person per calendar year. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Rehabilitation services | $50 copay, deductible does not apply, for office visit; 20% coinsurance for other outpatient services | 40% coinsurance | None. |
| | Habilitation services | $50 copay, deductible does not apply, for office visit; 20% coinsurance for other outpatient services | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | None. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | None. |
| | Hospice services | 20% coinsurance | 40% coinsurance | None. |
| **If your child needs dental or eye care** | Children's eye exam | No charge, deductible does not apply | Not covered | Applies from birth through age 5. |
| | Children's glasses | Not covered | Not covered | Not covered. |
| | Children's dental check-up | Not covered | Not covered | Not covered. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic Care
- Infertility treatment (except promotion of conception)
- Weight Loss Programs (nonsurgical obesity treatment)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator at (574) 389-4600 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage? Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$5,000** |
| **Specialist copayment** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $5,000 |
| Copayments | $0 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,560** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$5,000** |
| **Specialist copayment** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles* | $1,200 |
| Copayments | $1,900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,120** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$5,000** |
| **Specialist copayment** | **$60** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles* | $1,600 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,400** |

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

# Compliance Notices



**Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is 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' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

**Notice of Patient Protection**

If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the health plan generally may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your plan administrator or your Human Resources Department.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your plan administrator or Human Resources Department.

**Women's Health and Cancer Rights Act Notice**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the Plan Administrator.

**Newborns' and Mothers' Health Protection Act Notice**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48

hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Michelle's Law Notice**

Michelle's Law was signed into law effective January 1, 2010. This law generally allows seriously ill or injured fulltime college students, who are covered under their parent's health insurance plan, to take up to one year of medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

*Under the Patient Protection and Affordable Care Act, group health plans are required to offer coverage to dependent children up to age 26, regardless of student status.

**HIPAA Notice of Privacy Practices**

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect. Participants in insured group health plans may also receive a notice of privacy practices from those plans. You may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law. You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

**Genetic Information Nondiscrimination Act of 2008 (GINA)**

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any the benefits under included benefit plans. GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and
- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

**Mental Health Parity Act Notice**

The Mental Health Parity Act ("MHPA") requires that the annual or lifetime dollar limits on mental health benefits may not be lower than any such dollar limits for health and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. The lifetime limit ceased to apply effective January 1, 2011 and the annual limit ceased to apply effective January 1, 2014. Beginning with the 2010 plan year, federal law also will require that plans providing both health/surgical and mental health benefits may not impose more restrictive financial requirements (such as deductibles and copayments) and treatment limitations (such as limits on days of coverage) on mental health benefits than are imposed on health/surgical benefits.

# Compliance Notices



**Qualified Medical Child Support Order Notice**

A Qualified Medical Child Support Order (QMCSO) is a court order or an order issued by a state administrative agency in accordance with federal and state laws that requires an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant's group health plan. The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid. A QMCSO must be provided to the Plan Administrator to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee participant. If the Plan Administrator receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is qualified.

**Uniformed Services Employment and Reemployment Rights Act (USERRA)**

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you take leave under USERRA, to the extent required by USERRA, your Employer may continue to maintain your benefits on the same terms and conditions as if you were still an active employee.

Employees going into or returning from service in the uniformed services may have Plan rights mandated by USERRA. These rights apply only to employees and their dependents covered under the Plan before the employee left for military service. To be entitled to USERRA rights, the employee must give the employer advanced notice of the employee's absence from employment for uniformed service, unless precluded by military necessity or if it is otherwise impossible or unreasonable under all the circumstances. Additionally, subject to certain exceptions, the employee's absence from work may not exceed five years.

USERRA rights include up to 24 months of continued health care coverage. For periods of leave less than 31 days, the employee only needs to pay his or her normal portion of the premium. For periods of leave 31 days or more, coverage will only be extended upon payment of the entire cost of coverage plus a reasonable administrative fee.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

USERRA rights terminate if the employee's discharge from the uniformed service was a result of "dishonorable" or other undesirable conduct, the employee fails to report back to work or apply for reemployment within the time period required under USERRA, or if the employee fails to pay coverage premiums.

The time periods within which to elect and pay for USERRA continuation of coverage shall be the same time periods within which to elect and pay for COBRA coverage under the Plan. If both USERRA and COBRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage. Note also that state law may provide continuation and/or conversion coverage.

# Compliance Notices



### Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

---

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program<br>(HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |

# Compliance Notices



| GEORGIA – Medicaid | INDIANA – Medicaid |
|---|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/health-care-coverage/<br>Phone: 1-800-657-3672 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |

# Compliance Notices



| MONTANA – Medicaid | NEBRASKA – Medicaid |
|---|---|
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |

# Compliance Notices



| TEXAS – Medicaid | UTAH – Medicaid and CHIP |
|---|---|
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP)<br>Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website:<br>https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website:<br>https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

# Compliance Notices



## Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

**You are protected from balance billing for:**

**Emergency services**

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

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

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

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

**If you believe you've been wrongly billed**, contact the federal No Surprises Help Desk at 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

# Compliance Notices



## Important Notice from Forest River, Inc. About Your Prescription Drug Coverage and Medicare (CREDITABLE)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Forest River, Inc. Group Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Forest River, Inc. has determined that the prescription drug coverage offered by the Forest River, Inc. Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current Forest River, Inc. Group Health Plan coverage will not be affected. If you keep your current coverage and elect Medicare Part D, your Forest River, Inc. Group Health Plan coverage may coordinate with your Medicare Part D coverage. If you do decide to join a Medicare drug plan and drop your current Forest River, Inc. Group Health Plan coverage, be aware that you and your dependents will not be able to get this coverage back, unless you have a qualifying life event or until the next open enrollment.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Forest River, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have

that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage**

Contact the person listed below for further information.

**NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Forest River, Inc. changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Effective Date: 1/1/2026

Name of Entity/Sender: Forest River, Inc.

Contact--Position/Office: David Besinger – HR Director

Address: 55470 County Road 1, PO Box 3030, Elkhart, IN 46515

Phone Number: 574-367-3268

Distribution Date: 08/05/2025

# Compliance Notices



## SUMMARY ANNUAL REPORT

**For Forest River, Inc. Welfare Benefit Plan**

This is a summary of the annual report of the Forest River, Inc. Welfare Benefit Plan, EIN 20-3284366, Plan No. 510, for period 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Forest River, Inc. has committed itself to pay certain self-insured Medical claims incurred under the terms of the plan.

### Insurance Information

The plan has contracts with Vision Service Plan, Reliastar Life Insurance Company, Transamerica Life Insurance Company, Unum Life Insurance Company of America, Paramount Dental, and Provident Life and Accident Insurance Company to pay Dental, Vision, Life Insurance, Short-term Disability, Long-term Disability, Accidental Death and Dismemberment, Long Term Care, Critical Illness, Hospital, and Accident claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were $10,199,749.

### Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Forest River, Inc. at P.O. Box 3030, 900 County Road 1, Elkhart, IN, 46515 or by telephone at 574-389-4600.

You also have the legally protected right to examine the annual report at the main office of the plan (Forest River, Inc., P.O. Box 3030, 900 County Road 1, Elkhart, IN, 46515) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site www.efast.dol.gov.

### Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

FOREST RIVER

www.forestriverinc.com

900 County Road 1
P.O. Box 3030
Elkhart, Indiana 46515

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# Plan Endorsement #26-SP

| | | | |
|---|---|---|---|
| GROUP # | A22100 | | |
| EFFECTIVE DATE | January 1, 2026 | | |
| EMPLOYER ID# | 20-3284366 | PLAN #s | 501 |
| NAME OF PLAN | Forest River, Inc. Employee Benefits Plan | | |
| TYPE OF PLAN | $1,250 Plan | | |

The following wording is hereby added to the Plan:

Forest River, Inc. of Elkhart, Indiana hereby establishes a plan for payment of certain expenses for the benefit of its eligible employees to be known as Forest River, Inc. Employee Benefits Plan. The attached document serves as the summary plan description, plan description and plan document for the Plan.

Forest River, Inc. has caused this Plan to take effect as of 12:01 A.M. Eastern Time on January 1, 2026 at Elkhart, Indiana.

APPROVED AND ATTESTED:

BY Signed by: Dave Besinger 2A80C4A9E28D4A4... TITLE VP HR

DATE 09/10/2025 | 10:30:11 AM EDT

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# FOREST RIVER, INC.

900 County Road 1 North
Elkhart, IN 46514
Phone: (574) 389-4600

# $1,250 Plan

***This booklet describes the Medical benefits for Eligible Employees of Forest River, Inc.***

Information Applicable to Plan 501

Employer Identification Number
20-3284366

**The Benefits In This Booklet Are Effective**
**January 1, 2026**

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# TABLE OF CONTENTS

KEY INFORMATION ..... 1
PRE-CERTIFICATION PROGRAM ..... 5
SCHEDULE OF COVERED SERVICES AND PROVISIONS ..... 7
GENE THERAPY FOR DUCHENNE MUSCULAR DYSTROPHY (DMD) ..... 18
TRANSPLANTS ..... 19
TRAVEL AND LODGING EXPENSES ..... 22
EXCLUSIONS ..... 23
DEFINITIONS ..... 27
ELIGIBILITY ..... 38
EMPLOYER POLICIES AND PROCEDURES ..... 40
INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS ..... 41
NETWORK BENEFITS ..... 43
OUT-OF-NETWORK BENEFITS ..... 44
PROCEDURES FOR FILING CLAIMS ..... 45
THIS PLAN AND MEDICARE ..... 47
GENERAL PROVISIONS ..... 48
COORDINATION OF BENEFITS (COB) ..... 62
COMPLIANCE REGULATIONS ..... 64
NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA ..... 66
ERISA RIGHTS SECTION ..... 72
STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “PRIVACY STANDARDS”) ..... 74
NOTICE OF PRIVACY PRACTICES ..... 77
STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “SECURITY STANDARDS”) ... 88

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# KEY INFORMATION

**EMPLOYER/COMPANY/PLAN ADMINISTRATOR/PLAN SPONSOR CONTACT INFORMATION:**
Forest River, Inc.
900 County Road 1 North
Elkhart, IN 46514
Phone: (574) 389-4600

**EMPLOYER/COMPANY IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):**
20-3284366

**PLAN NAME:**
Forest River, Inc. Employee Benefits Plan

**PLAN CONTACT INFORMATION:**
Human Resources Department
Forest River, Inc.
900 County Road 1 North
Elkhart, IN 46514
Phone: (574) 389-4600

**PLAN NUMBER:**
501

**STOP LOSS COVERAGE:**
The Company has purchased specific and aggregate stop-loss reinsurance coverage.

**GROUP NUMBER:**
A22100

**SPD EFFECTIVE DATE:**
January 1, 2026

**PLAN YEAR:**
The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends the last day of each December.

**TYPE OF PLAN:**
Medical and prescription drugs

**NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:**
Allied Benefit Systems, LLC
P. O. Box 211651
Eagan, MN 55121
Phone: (312) 906-8080 or (800) 288-2078 (outside IL)

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**PRIVACY OFFICERS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA):**

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

- Human Resources Manager.
- Staff designated by Human Resources Manager.
- Chief Financial Officer.
- Staff designated by Chief Financial Officer.

**ELIGIBILITY:**

- Employees: A person directly employed in the regular business of, and compensated for, services by the Company. This definition specifically excludes independent contractors and seasonal Employees.

- Retirees: This Plan does not cover retirees or their Dependents.

- Dependents Including:

    - Dependent Children: Child(ren) from birth to the last day of the month they attain age 26 consisting of natural children, stepchildren, foster children, adopted children, children placed for adoption, and children for whom You are the court-appointed legal guardian.

    - Spouse: This Plan defines "marriage" as both 1) a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage, and 2) a legal union between two persons of the same sex, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement.

    - Domestic Partners: **This Plan does not cover domestic partners**.

**WORKING SPOUSE COVERAGE PROVISION:**

No surcharge will be levied if the spouse of an eligible Employee is eligible for coverage through his employer and chooses coverage from this Plan.

**ENROLLMENT:**

- **Enrollment Waiting Period:**

  If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Employee or Dependent becomes eligible for coverage under the terms of this Plan.

- **Regular Full-time Employees:** You are eligible for coverage on the first day of the month coinciding with or following the date upon completion of 60 days of regular employment in a covered position.
- **Employees Under Special Contract:** You are eligible for coverage on the date as stated by the Employees contract.
- **Part-time to Full-Time:** Service is credited toward the Employee's waiting period from original hire date.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

- **Open Enrollment Period:**
  Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer.

- **Late Enrollment Period:**
  This Plan does not have a Late Enrollment period.

**TERMINATION OF COVERAGE:**

1. **Employee:** The coverage of any Employee covered under this Plan shall terminate on the earliest of the following**:**
   - The Saturday after the last day the Employee ceases to be eligible for coverage under the Plan, as listed in the Key Information section; or
   - The date of termination of the Plan.

2. **Dependent children (attaining age 26):** The coverage of Dependent children attaining age 26 covered under this Plan shall terminate on the earliest of the following:
   - The last day of the month such individual ceases to meet the definition of Dependent, as listed in the Key Information section; or
   - The date the Employee's coverage terminates under the Plan.

3. **Dependent (all others):** The coverage of any Dependent (other than identified above) covered under this Plan shall terminate on the earliest of the following:
   - The Saturday after the last day such individual ceases to meet the definition of Dependent, as listed in the Key Information section, however in the event of a divorce, coverage under this Plan shall terminate on the date the divorce is finalized, or
   - The date the Employee's coverage terminates under the Plan.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**IMPORTANT NETWORK CONTACT INFORMATION:**

| Function | Network Name | Claims Filing Information | Phone Number | URL |
|---|---|---|---|---|
| **PPO Network** | Anthem | Please file all claims with the Blue Cross and Blue Shield Plan in the state where services are rendered. | 800.676.BLUE | www.anthem.com |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# PRE-CERTIFICATION PROGRAM

Your Plan also includes a **pre-certification program**. The toll-free number You must use for pre-certification is shown on Your member ID card. **Failure to follow the guidelines listed below will subject Your benefits to a penalty for non-compliance as discussed in this section and referenced in the schedule of covered services and provisions.**

**The following services require pre-certification:**

1. Inpatient Hospital admissions.
2. Oncology Treatment.
    a. Chemotherapy (Including oral).
    b. Radiation Therapy.
    c. Oncology and transplant related injections, infusions and treatment (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine).

**If Your Physician recommends any service listed above, please follow these steps:**

1. Notify Your Physician that You participate in a pre-certification program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.

2. You or Your Physician must call the number shown on Your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission. Note: For exceptions, please refer to the section of this document entitled "Compliance Regulations," and see the subheading "Statement of Rights Under the Newborns' and Mothers' Health Protection Act".

3. If you are not able to call in advance, pre-certification is required following admission.

The following information will be needed to pre-certify:

| **Regarding Patient:** | **Regarding Employee:** |
|---|---|
| Name | Name |
| Address | Address |
| Telephone # | Telephone # |
| Date of Birth | Date of Birth |
| Relationship to Employee | Gender |
| Physician's Name | Social Security Number |
| Physician's Phone Number | Name of Employer |
| Hospital/Address | Name of Claims Processor:<br>*Allied Benefit Systems, LLC* |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

4. A nurse may call Your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.

5. When You or Your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:

   a. The facility can verify that pre-certification has been done and can track expected length of stay.

   b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

**Note**: Pre-certification assists in determining medical necessity and the best place for treatment. This service, however, does not guarantee payment, which is subject to eligibility and coverage at the time services are rendered.

**PENALTY FOR NON-COMPLIANCE:**

Unless prohibited under federal law, any non-compliance penalty specified in the Schedule of Covered Services and Provisions will apply under one or more of the following circumstances: a) a pre-certification call is not made according to the instructions within this section; b) an Inpatient stay exceeds the amount of days pre-certified; or c) a patient is admitted as an Inpatient when treatment could have been performed on an Outpatient basis.

This penalty will be applied in addition to any applicable Deductible and will not be applied to any Out-of-Pocket Maximum as specified in the "Schedule of Covered Services and Provisions". The penalty will be applied to Covered Services that were incurred during the days that were not pre-certified.

## PRE-NOTIFICATION

The following procedures are generally not covered by the Plan unless medically appropriate. Therefore, it is strongly recommended that a pre-notification of the following procedures be obtained before treatment. The toll-free number You should use for pre-notification is 800-892-1893.

Procedures for which pre-notification is recommended are:

1. Non-orthopedic imaging for CT, MRI, and PET Scans.
2. Neoplasm biopsies.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# SCHEDULE OF COVERED SERVICES AND PROVISIONS

## I. MEDICAL CARE BENEFITS:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Calendar Year Deductible** *(taken before benefits are payable unless waived)*<br>*This is an embedded Deductible, meaning each covered family member only needs to satisfy his or her individual Deductible, not the entire Family Deductible, prior to receiving plan benefits. The balance of the Family Deductible can be satisfied by one member or a combination of remaining family members.* | $1,250 per person<br>$2,500 per family | $3,000 per person<br>$6,000 per family |
| **Deductible Carry-Over** | Any Covered Services incurred during October, November and/or December which are applied to the Covered Person's Deductible will also "carry-over" to the following year's Deductible. | |
| **Out-of-Pocket Maximum per Calendar Year** *(*medical co-pays, Co-Insurance and Deductibles count towards the Out-of-Pocket Maximum)<br>*After amount is reached, 100% level of benefits applies for that Calendar Year.* The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum:<br>• Rx co-pays (see separate Prescription Drug Out-of-Pocket listed below)<br>• "Non-compliance penalty" (for failure to abide by pre-certification requirements).<br>• Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit.<br>*This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits paid at 100%. The balance of the family Out-of-Pocket Maximum can be satisfied by one member or a combination of remaining family members.* | $4,000 per person<br>$8,000 per family | $10,000 per person<br>$20,000 per family |
| **Prescription Drug Out-of-Pocket Maximum per Calendar Year**<br>*After amount is reached, the Plan will pay 100% for prescription drugs for the remainder of the Calendar Year.* | $2,500 per person<br>$5,000 per family | |
| **Calendar Year Benefit Maximum** | Unlimited | |
| **Precertification Penalty for Non-Compliance: Certain benefits are subject to a $250 penalty** per occurrence ***(in addition to Deductible)*** for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section for additional information. | Allied Care<br>1-800-892-1893 | |
| **Claims Filing Limit** | All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred. | |
| **Coordination of Benefits** | If it is determined that this Plan is the secondary payer, benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges. | |
| **In-network and out-of-network Deductibles and Out-of-Pocket Maximums are "aggregated," such that Covered Services applied to one also apply to the other.** | | |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## II. PRESCRIPTION DRUG BENEFIT:

| COVERED SERVICES and PROVISIONS | In-Network / Out-of-Network |
|---|---|
| *Your Prescription Drug Benefit is administered by Capital Rx. For prescription drug questions please call 1-833-599-0979 or visit www.cap-rx.com.* | |
| *If member requests brand only when a generic is available, the member will be charged the generic co-pay plus the cost difference between the brand and generic medication. The amount of this cost difference does not apply to the Deductibles or Out-of-Pocket Maximums.* | |
| **Separate Prescription Drug Deductible per Calendar Year** | $100 per person<br>$200 per family |
| **Prescription Drug Out-of-Pocket Maximum per Calendar Year**<br><br>*After amount is reached, the Plan will pay 100% for prescription drugs for the remainder of the Calendar Year.* | $2,500 per person<br>$5,000 per family |
| **Prescription Drug Card Benefit** *(up to 30-day supply per prescription through participating pharmacies)* | 10% up to a maximum co-pay of $20/generic,<br>20% up to a maximum co-pay of $50/brand,<br>30% up to a maximum co-pay of $150/Non-preferred brand<br>(per prescription).<br>After Deductible |
| **Extended Retail Pharmacy Drug Benefit** *(up to 90-day supply per prescription through any participating pharmacy) except where prohibited by state or federal law.* | $25/generic, $50/brand, $150/Non-preferred brand (per prescription).<br>After Deductible |
| **Mail-Order Drug Benefit** *(up to 90-day supply per prescription through mail order) except where prohibited by state or federal law.* | $25/generic, $50/brand, $150/Non-preferred brand (per prescription).<br>After Deductible |
| **Mail-Order/Extended Retail Pharmacy Requirement** | Optional |
| **Specialty Drug Benefit** *(up to 30-day supply per prescription, includes certain injectable medications) except where prohibited by state or federal law.* | 40% up to a maximum co-pay of $200,<br>After Deductible |
| *Note: Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations* | |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## III. PREVENTIVE CARE SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Preventive Care Services** - (*must be billed with a routine diagnosis).*<br><br>This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years).<br><br>*This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.*<br><br>This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests, *see Outpatient services for more details.* | 100%<br>Deductible waived. | Not Covered |
| **Routine visits related to Obesity management** | 100%<br>Deductible waived. | Not Covered |
| **Preventive Care Services – Mammograms** *(regardless of diagnosis)*<br><br>• Mammograms (including 3D), once every year (age 40 or older)<br><br>*Note: The first mammogram in a Calendar Year shall be paid according to this benefit regardless of diagnosis, all other diagnostic mammograms within the same Calendar Year shall be paid at standard co-insurance.* | 100%<br>Deductible waived. | Not Covered |
| **Preventive Care Services – Colonoscopy/Sigmoidoscopy**- (*must be billed with a routine diagnosis).*<br><br>• Choice between a sigmoidoscopy or a colonoscopy once every 5 years (age 45 or older) | 100%<br>Deductible waived. | Not Covered |
| **Family history benefit**<br><br>*Any age or visit limit maximums will not apply when family history is the only diagnosis billed for routine tests. This benefit is limited to the services referenced within the Recommendations of the United States Preventive Service Task Force, as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine*. | 100%<br>Deductible waived. | Not Covered |
| **Family Planning - Permanent Procedures for Women**<br><br>*Includes:*<br>• *Sterilization.* | 100%<br>Deductible waived. | Not Covered |
| **Family Planning – Temporary Procedures**<br><br>*Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.* | 100%<br>Deductible waived. | Not Covered |
| **Breast Pumps and Supplies (Includes one breast pump per pregnancy and certain covered supplies purchased through a retail supplier).** | 100%<br>Deductible waived. | 100%<br>Deductible waived. |
| **Immunizations (including flu shots) provided at retail clinics** *such as, but not limited to, Walgreens, CVS, Walmart, Jewel-Osco, etc.* | 100%<br>Deductible waived. | 100%<br>Deductible waived. |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## IV. PHYSICIAN SERVICES:

| COVERED SERVICES and PROVISIONS<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| TELADOC™<br>Teladoc provides access to a national network of U.S. board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone, by calling 1-800-Teladoc (835-2362), or online video consultations by accessing www.teladoc.com. Teladoc does not replace the existing primary care physician relationship, but enhances it as a convenient, affordable alternative for medical care. | 100%<br>Deductible Waived | |
| **Virtual Physician charges** | Paid same as any other service according to type of service and provider. | |
| **Minor Medical Services** *to the extent available and provided* **at Retail Clinics** *such as, but not limited to, Walgreen's, CVS, Walmart, Osco, etc.* ***This does not include the cost of any take home medications or items provided, or the charge for any other provider in association with the visit.*** *Any such charges will be covered as shown elsewhere in this schedule.* | $20 co-pay, then paid at 100%<br>Deductible waived<br>(Co-pay applies to the in-network Out-of-Pocket Maximum) | |
| **Physician Office Visits –** *includes all services done during the office visit.*<br>*Allied considers the following doctors as primary care physicians, all others would be specialists:*<br>• *General Practice.*<br>• *Family Practice.*<br>• *OB/Gyn.*<br>• *Internal Medicine.*<br>• *Osteopaths.*<br>• *Pediatricians.*<br>• *Nurse Practitioners.*<br>• *Physician Assistants.*<br>• *All covered Mental Health providers* | $20 co-pay, then paid at 100%<br>Deductible waived | 60% |
| **Urgent Care** - *includes facility fees and all other services done during the urgent care visit.* | $30 co-pay, then paid at 100%<br>Deductible waived | 60% |
| **Specialist Office Visits –** *includes all services done during the office visit.* | $45 co-pay, then paid at 100%<br>Deductible waived | 60% |
| **Second Surgical Opinion** | 100%<br>Deductible waived | 100%<br>Deductible waived |
| **Emergency Room Physician Care** | Please refer to Emergency Room Services benefit in Section VI. | |
| **Physical/Occupational/Speech Therapy - Office Services** | $40 co-pay per visit, then paid at 100%<br>Deductible waived | 60% |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## IV. PHYSICIAN SERVICES:

| COVERED SERVICES and PROVISIONS<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Physical/Occupational/Speech Therapy - Outpatient Services** | 80% | 60% |
| **All Care Rendered by a Chiropractor** | $40 co-pay per visit, then paid at 100%<br>Deductible waived | 60% |
| **Anesthesia and its Administration** *(Inpatient/Outpatient)* | 80% | 60% |
| **Other Physician Services**<br>*Does not include Outpatient/Independent Laboratory labs and X-rays; please see Section V for additional benefit coverage information.* | 80% | 60% |
| **If a referral is made to a non-network Physician or non-network specialist/facility by a network Physician** (due to Medically Necessary services not being available In-Network). | N/A | Paid same as In Network. |
| **Non-Network Physician Services Received at a Network Hospital**<br>If services are performed by a non-network Physician/specialist, who is requested or required by that network Hospital, the charges will be covered as if rendered by a network Physician/specialist. | N/A | Paid same as In-Network. |

## V. OUTPATIENT/INDEPENDENT LABORATORY RADIOLOGY/PATHOLOGY SERVICES, INCLUDING ADMINISTRATION AND MRI, PET, AND CT SCANS:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Independent Laboratory Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services**<br>*Does not include above services performed in conjunction with the following:*<br>• *Emergency Room Services.*<br>• *Urgent Care Services.*<br>*Does not include MRI, PET or CT scans.* | 90% | 60% |
| **Outpatient Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services**<br>*Does not include above services performed in conjunction with the following:*<br>• *Emergency Room Services.*<br>• *Urgent Care Services.*<br>*Does not include MRI, PET or CT scans.* | 80% | 60% |
| **Outpatient Imaging Services (MRI, PET, and CT scans)** | 80% | 60% |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## VI. FACILITY SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Emergency Room Services**<br>Co-pay waived if admitted to Hospital directly from Emergency Room.<br><br>*Note: See the "Out-of-Network Benefits" section for more information regarding out of network Emergency Room Services.* | $450 co-pay, Deductible applies, then paid at 80% | Paid Same as in-network |
| **Inpatient Hospital Services**<br>*Coverage is limited to:*<br>• *Room and board not to exceed the semi-private room rate.*<br>• *Necessary services and supplies including an intensive care unit and a cardiac care unit.*<br>• *If admitted through the Hospital emergency room, this benefit will be covered at the in-network level. Notice and consent rules may apply to certain post-stabilization items and services. See Emergency Room Services in the "Definitions" section.*<br>*Note: Room and board subject to the payment of semi-private room rate, unless the Hospital only has private rooms.* | 80% | 60% |
| **Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures** | 90% | 60% |
| **Outpatient Hospital Facility Charges** | 80% | 60% |
| **Renal Dialysis** | 80% | 60% |
| **Urgent Care Services – facility fees** | Please refer to Urgent Care Services benefit in Section IV. | |

## VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **BEHAVIOR HEALTH BENEFIT (Mental/Nervous/Substance Use Disorders)** | | |
| **Treatment for Mental/Nervous and Substance Use Disorders**<br>*Please see the definitions of Physician and Hospital for further detail.* | Paid same as any other service according to type of service, provider and place of service. | |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## VIII. TRANSPLANT SERVICES:

| COVERED SERVICES and PROVISIONS<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Organ or Tissue Transplant Procedures at a Blue Distinction Center facility or Anthem Center of Medical Excellence)** | 100%<br>Deductible waived | |
| **Organ or Tissue Transplant Procedures (other than provided at a Blue Distinction Center facility or Anthem Center of Medical Excellence)**<br>**For cornea, skin, or cartilage transplants:**<br>*The Covered Person, who is the transplant recipient, must receive 2 opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.* | Coverage and Benefit Level based upon place and type of service. | Coverage and Benefit Level based upon place and type of service. |
| **For all other Organ and Tissue Transplants:**<br>*For specific details on all elements of this coverage, please refer to the Transplants section.* | Coverage and Benefit Level based upon place and type of service. | Not Covered |

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Abortion-** *only if mother's life is endangered if pregnancy is carried to term, or if medically indicated due to complication with pregnancy.* | 80% | 60% |
| **Acupuncture** | Not Covered | |
| **Assisted Reproduction** | Not Covered | |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## IX. OTHER COVERED SERVICES:

| **COVERED SERVICES and PROVISIONS**<br><br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br><br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Autism Spectrum Disorders**<br>*For those diagnosed with this disorder, the following treatments are covered:*<br>• *Psychiatric and Psychological care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist or psychologist;*<br>• *Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.*<br>*Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.* | 80%<br>Except as may be covered differently for specific services listed elsewhere in the schedule. | 60%<br>Except as may be covered differently for specific services listed elsewhere in the schedule. |
| **Casts, Splints, Trusses, and Braces** | 80% | 60% |
| **Contact Lenses or Glasses Following Cataract Surgery**<br>*Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.* | 80% | 60% |
| **Dental Treatment** *when rendered by a Physician, dentist, or oral surgeon for* ***a*** **fractured jaw** *or for* **accidental Injuries to natural teeth within 6 months** *after the accident (replacement or repair of a denture not covered)*; *removal of* **total bony impacted teeth**; *charges for* **medical care, services** *and* **supplies** *furnished by a Hospital during Medically Necessary confinement in connection with* dental treatment. | 80% | 60% |
| **Durable Medical Equipment**<br>*Includes:*<br>• *Cost to purchase or rent up to purchase price.*<br>• *Insulin pump, glucose monitors and other diabetic supplies when Medically Necessary and not covered though Your prescription drug vendor.*<br>• *Equipment for administration of oxygen.*<br>• *Equipment repair or replacement.* | 80% | 60% |
| **Family Planning - Permanent Procedures for Men**<br>*Includes:*<br>• *Sterilization.*<br>  ○ *Male vasectomy.* | 80% | 60% |
| **Foot Orthotics** | Not covered | |
| **Gender Affirming Surgery (including any associated labs and x-rays)** | 80% | 60% |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br><br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br><br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Hearing exams**<br>*Hearing screenings from birth through age 21 are covered under the Preventive Care benefit.* | 80% | 60% |
| **Home Health Care**<br>*Limited to a maximum of 60 home care visits per Covered Person per Calendar Year.*<br>*Each 4 hours of service by a home health aide in a 24-hour period will be considered 1 home health visit.*<br>*One visit by any other provider of services will be counted as 1 visit.* | 80% | 60% |
| **Hospice Care**<br>*Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.* | 80% | 60% |
| **Infertility Testing**<br>*Limited to Covered Services necessary to diagnose this condition only.*<br>*This benefit does not cover charges in connection with the promotion of conception (see Assisted Reproduction benefit for details). Infertility means the inability to conceive a child, or the inability to sustain a successful pregnancy* | Paid same as any other service according to type of service, provider and place of service. | |
| **Infusion therapy and Injections when administered in a Physician's office or facility**<br>*The first dose of infusion therapy may be given at the Physician's facility of choice, including Outpatient Hospitals, free-standing facilities and home care. Any subsequent dose may also be given at the Physician's facility of choice, but only when clinically appropriate and at a lower cost than other sites of administration.*<br>*Note: Self-administered injections, topical solutions, and oral specialty medications are not covered under this Plan. Delandistrogene moxeparvovec-rokl (ELEVIDYS) requires medical necessity as defined on pages 9/10. If Plan requirements are not met, the therapy is excluded.* | 80% | 60% |
| **Mastectomy Related Treatment**<br>*Includes charges in accordance with the provisions detailed under the definition of "Reconstructive Breast Surgery."* | 80% | 60% |
| **Non-Surgical Obesity Treatment** | 80% | 60% |
| **Nutritional Counseling, regardless of underlying covered condition** | 80% | 60% |
| **Obesity Surgery** | Not Covered | |
| **Orthopedic Shoes**<br>*Limited to specially molded and Medically Necessary shoes.*<br>*Limited to 1 pair per Covered Person every 24 months.* | 80% | 60% |
| **Private Duty Nursing Services** | Not Covered | |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br><br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br><br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Professional Ambulance Service**<br>*Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.*<br>*Note: See the "Out-of-Network Benefits" section for more information regarding out of network Air Ambulance services.* | 80% | 80%<br>(Subject to the in-network deductible and Out-of-Pocket maximum) |
| **Prosthetic Medical Appliances (including Artificial Limbs, Eyes and Larynx)**<br>*Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.* | 80% | 60% |
| **Routine Newborn Nursery Care** *(including circumcision)* | 80% | 60% |
| **Self-administered injections, topical solution, and oral specialty prescription medication** | Not Covered | |
| ***Services/Items for Covered Persons Residing Outside the PPO Network Area*** | *N/A* | *Paid same as any other in-network service according to type of service, provider and place of service.* |
| **Skilled Nursing Facility**<br>*Includes Extended Care Facility.*<br>*Limited to 60 days per Covered Person per Calendar Year.*<br>*Limited to the usual charge of the facility for semi-private care, including room and board and all other services.* | 80% | 60% |
| **Sleep Studies (*home)*** | 80% | 60% |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br><br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br><br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Sleep Studies *(In-lab, facility) ages 18 and over***<br>In order to be eligible, the member must have **one of the following**:<br>• Excessive daytime sleepiness<br>• Epworth Sleepiness Scale (ESS) score of 10 or greater<br>• Witnessed apneas, choking, or gasping<br>**AND one of the following** comorbid conditions:<br>• moderate to severe pulmonary disease<br>• neuromuscular disease<br>• stroke<br>• epilepsy<br>• congestive heart failure (NYHA class III or IV)<br>• pulmonary hypertension<br>• chronic opioid medication use<br>• super obesity (BMI > 45)<br>• periodic limb movement disorder<br>• parasomnias<br>• severe insomnia<br>• narcolepsy<br>• central sleep apnea or complex sleep apnea<br>• negative or technically inadequate home sleep study results<br>• Inability to use portable monitoring equipment safely at home. | 80% | 60% |
| **Sleep Studies *(In-lab, facility) ages 17 and under***<br>In order to be eligible, the member must be under 18 years of age and have one of the following indications:<br>• Snoring<br>• Hypersomnia<br>• Suspected obstructive sleep apnea<br>• Suspected narcolepsy<br>• Suspected parasomnia<br>• Suspected restless leg syndrome<br>• Suspected periodic limb movement disorder<br>• Suspected congenital central alveolar hypoventilation syndrome<br>• Suspected sleep-related hypoventilation due to neuromuscular disorders or chest wall deformities<br>• After adenotonsillectomy or pharyngeal surgery for OSA | 80% | 60% |
| **TMJ** *(Temporomandibular Joint Dysfunction)*<br>*Limited to $1,000 Maximum paid per Covered Person per Lifetime.*<br>*Benefit does not include charges for orthodontic services.* | 80% | 60% |
| **Wigs** *for hair loss resulting from the treatment of cancer.* | 80% | 60% |
| **Please Refer to the Pre-Certification Program, Transplants, and Exclusions sections for additional coverage details.** | | |

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# GENE THERAPY FOR DUCHENNE MUSCULAR DYSTROPHY (DMD)

Gene therapy for Duchenne muscular dystrophy (DMD), a rare and serious genetic disease affecting muscle strength and movement. Gene therapy is being proposed as a one-time treatment to significantly lessen the severity of DMD. At this time, one gene therapy has been approved by the Food and Drug Administration (FDA) to treat DMD: delandistrogene moxeparvovec-rokl (ELEVIDYS), an adeno-associated virus vector-based gene therapy.

**Note:** Please refer to the applicable clinical pharmacy criteria used by the Plan for information regarding disease-modifying treatments for DMD; for example: casimersen (Amondys 45), viltolarsen (Viltepso), and golodirsen (Vyondys 53).

**Medically Necessary:**
A one-time infusion of delandistrogene moxeparvovec-rokl (ELEVIDYS) is considered **Medically Necessary** in individuals who meet **all** of the following criteria:

A. Diagnosis of Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene; **and**
B. No deletion in exon 8 or exon 9 in DMD gene; **and**
C. Ambulatory; **and**
D. Age 4 through 5 years (at least 4 years 0 days and less than 6 years old); **and**
E. Anti-AAVrh74 total binding antibody titers less than 1:400; **and**
F. Absence of active infection; **and**
G. Absence of significant liver dysfunction or disease, defined as *at least one of the following*:
    1. Preexisting liver impairment; **or**
    2. Chronic hepatic condition; **or**
    3. Acute liver disease (e.g., acute hepatic viral infection).

**Investigational and Not Medically Necessary:**
Delandistrogene moxeparvovec-rokl (ELEVIDYS) is considered **investigational and not Medically Necessary** when the criteria above are not met.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# TRANSPLANTS

**PREFERRED TRANSPLANT NETWORK FACILITY:**

A Preferred Transplant Network Facility is a facility contracted with the Plan's Preferred Transplant Network (PTN) to furnish particular services and supplies to You or Your Dependent in connection with one or more highly specialized medical procedures. The maximum charge made by the PTN for such services and supplies will be the amount agreed to between the Plan's PTN and the PTN facility.

**TRANSPLANT EXPENSES**

Once it has been determined that You or one of Your Dependents may require an ***organ*** transplant, You or Your Physician should follow the guidelines listed in the Pre-Certification Program to coordinate Your transplant care. You must follow any pre-certification requirements. ***Organ*** means solid organ, stem cell, bone marrow, or tissue.

While all organ transplants (other than cornea or skin transplants) are covered only under this section, benefits may vary if a PTN facility or non-PTN facility is used. The PTN facility must be specifically approved and designated by the PTN to perform the procedure You require. A transplant will be covered as in-network only if performed in a facility that has been designated as a PTN facility for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as a PTN facility, even if the facility is considered as a network facility for other types of services, will not be considered in-network.

## COVERED TRANSPLANT EXPENSES

Covered transplant expenses include the following (unless stipulated otherwise by a separate transplant agreement between the Plan, PTN, and PTN facility):

- Inpatient and Outpatient expenses directly related to a transplant**.**
- Charges made by a Physician or transplant team.
- Charges made by a Hospital**,** outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the PTN facility during the transplant process. These services and supplies may include: physical therapy, speech therapy and occupational therapy; bio-medicals and immunosuppressants; and home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date You are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes Inpatient and Outpatient services for all covered transplant-related health services and supplies provided to You and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during Your Inpatient stay or Outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during Your Inpatient stay or Outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following organ transplants will be considered one transplant occurrence:

- Heart transplant.
- Lung transplant.
- Heart/lung transplant.
- Simultaneous Pancreas Kidney (SPK) transplant.
- Pancreas transplant.
- Kidney transplant.
- Liver transplant.
- Intestine transplant.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant surgery.
- Sequential transplants.
- Re-transplant of same organ type within 180 days of the first transplant.
- Any other single organ transplant, unless otherwise excluded under the Plan.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

The following will be considered to be more than one transplant occurrence:

- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

***Limitations***

The transplant coverage does not include charges for:

- Outpatient drugs, including bio-medicals and immunosuppressants, not expressly related to an Outpatient transplant occurrence.
- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the transplant occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.
- For donor services if You or Your covered Dependent are a donor.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# TRAVEL AND LODGING EXPENSES

**Travel and lodging expenses** are covered under the Plan when necessary to obtain any type of care covered by the Plan when the care is not available from any provider or facility within 100 miles from the patient's principal residence. Coverage of travel and lodging expenses will be limited to the closest provider or facility capable of providing the service(s) at issue, and coverage of travel and lodging expenses will only be provided in connection with obtaining services that are lawfully provided in the jurisdiction where they are performed.

Travel shall be reimbursed between the patient's home and the provider or facility for round trip (air, train or bus) transportation costs, including local transportation (such as taxi, rideshare, or public transit) when required. Only transportation costs that are reasonable in amount (for example, coach class only) will be covered. If traveling by auto to the facility, reasonable mileage, parking and toll costs are reimbursed. Reasonable mileage reimbursement shall be limited to the tax-free cap authorized by the Federal government for medical travel, as adjusted (up or down) for inflation.

Reimbursement of expenses incurred by the patient for lodging is limited to a maximum rate of $50 per night, payable at 100% Deductible waived. If a traveling companion is necessary to enable the patient to receive medical care, the companion's reasonable travel and lodging expenses will also be covered, with lodging expenses also reimbursed at a maximum rate of $50 per night, payable at 100% Deductible waived. Travel & lodging reimbursement is limited to a total cap of $10,000 per Calendar Year, payable at 100% Deductible waived, which is the combined maximum for both the patient and companion and applies collectively to all trips taken in a Calendar Year.

Third-party documentation, such as receipts, must be provided to substantiate any claimed reimbursement of travel and lodging expenses.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions (unless specifically stated within the Schedule of Covered Services and Provisions):

1. for or in connection with an Injury or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation, Occupational Disease, or similar law;
2. for care and treatment of an Injury or Illness arising out of, or in the course of, any employment for wage or profit;
3. in a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;
4. for charges which the Covered Person is not legally required to pay or for charges which would not have been made if no coverage had existed;
5. which are not Reasonable and/or in excess of Usual and Customary Charges (depending on contract provisions, this limitation may not apply to charges from network providers or non-network providers who are utilized as a result of requests or requirements of network providers), unless otherwise set forth in the "Out-of-Network Benefits" section;
6. which are for care or treatment which is not Medically Necessary;
7. for custodial care (Expenses incurred to assist a person in daily living activities are considered costs for custodial care. Costs for medical maintenance services and supplies in connection with custodial care due to age, mental or physical conditions, are not covered if such care cannot reasonably be expected to improve a medical condition.);
8. due to accidental bodily Injury or Illness resulting from participation in an insurrection or riot, or participation in the commission of an assault or felony;
9. for purchase or rental of personal comfort items or supplies of common use; for purchase or rental of blood pressure kits, exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steam rooms and/or swimming pools;
10. for non-medical expenses such as preparing medical reports, itemized bills or charges for mailing;
11. for training, educational instructions or materials, even if they are performed or prescribed by a Physician (except as stated in the Schedule of Covered Services);
12. for legal fees and expenses incurred in obtaining medical treatment;
13. for genetic testing and counseling (except as may be specifically stated as covered elsewhere in this document);

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

14. for Friday and Saturday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24-hour period immediately following admission;
15. for treatment by a Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N) if the Physician or nurse is related by blood, marriage, or by legal adoption to either the Covered Person or a spouse, or ordinarily resides with the Covered Person;
16. for any expense in excess of any maximum or limit as stated elsewhere in this document;
17. for failure to provide any additional documentation or information as may be requested pursuant to the "Procedures For Filing Claims" section of this Plan;
18. for charges for travel or accommodations, whether or not recommended by a Physician, unless specifically stated as covered;
19. for charges incurred before coverage was effective or after it was terminated;
20. for charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material;
21. except as stated in the Schedule of Covered Services and Provisions, 1) for treatment of or to the teeth, the nerves or roots of the teeth, and 2) for the repair or replacement of a denture;
22. for research studies not reasonably necessary to the treatment of an Illness or Injury;
23. This Exclusion is intentionally left blank;
24. This Exclusion is intentionally left blank;
25. for treatment for sexual dysfunction or inadequacy (except as may be covered under the prescription drug benefit), including implants and related hormone treatment;
26. for vitamins (except prescription pre-natal and pediatric vitamins); for over-the-counter drugs regardless of being prescribed by a Physician, unless required by federal law;
27. for routine foot care such as removal of corns, calluses or toenails, except in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy;
28. for splints or braces for non-medical purposes (i.e. supports worn primarily during participation in sports or similar physical activities);
29. for any form of medication or treatment not prescribed in relation to an Injury, Illness or pregnancy, unless stated as covered elsewhere in this document;
30. for growth hormones for children with short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
31. on account of any declared or undeclared act of war;

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

32. for charges in connection with Cosmetic Surgery/Treatment, except to correct deformities resulting from Injuries sustained in an accident; or due to an Illness such as breast cancer (including all services mandated by federal provisions related to mastectomy treatment – see definition of "Reconstructive Breast Surgery Coverage"); or to correct a functional disorder (functional disorders do not include mental or emotional distress related to a physical condition); or unless treatment is for correction of a functional abnormal congenital condition;
33. This Exclusion is intentionally left blank;
34. for expenses incurred for cryo-preservation and storage of sperm, eggs and embryos;
35. for charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies;
36. for special education services (unless specifically referenced in the Schedule of Covered Services);
37. for experimental or investigational services; or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States;
38. for routine eye examinations, unless required by federal law; for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses; for any procedure, treatment or exam in connection with refractive disorders; for eye surgery such as radial keratotomy;
39. This Exclusion is intentionally left blank;
40. for hearing aids, or the fitting thereof;
41. for instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician (except as referenced in the Schedule of Covered Services);
42. for surgery or treatment for obesity (except as referenced in the Schedule of Covered Services);
43. for surgical reversal of elective sterilizations; for elective abortions;
44. for chelation (metallic ion) therapy, except as approved by the Food and Drug Administration;
45. for "nicotine patches" or other forms of anti-smoking medication (except as covered under the prescription drug benefit);
46. for care and treatment for hair loss including wigs, hair transplants, hair implants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy;

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

47. for any service for assisted reproduction (including in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer); however, diagnosis and treatment of medical conditions (such as endometriosis) that may contribute to the condition of infertility are covered;
48. for services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;
49. This Exclusion is intentionally left blank;
50. for marital counseling services;
51. This Exclusion is intentionally left blank;
52. for expenses for injuries incurred in the commission of a criminal act involving the use of alcohol or illegal drugs;
53. This Exclusion is intentionally left blank;
54. This Exclusion is intentionally left blank;
55. for out-of-network facility charges (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits" section), payment will be limited to 175% of the Medicare DRG Reimbursement Rate or the Medicare APC Reimbursement Rate (whichever is appropriate);
56. for out-of-network professional charges billed on a Form CMS-1500, payment will be limited to 135% of the Medicare fee schedule (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits" section);
57. This Exclusion is intentionally left blank;
58. This Exclusion is intentionally left blank;
59. This Exclusion is intentionally left blank;
60. This Exclusion is intentionally left blank;
61. This Exclusion is intentionally left blank;
62. This Exclusion is intentionally left blank;
63. This Exclusion is intentionally left blank;
64. for provider charges claimed as a result of purported lost discounts;
65. for charges for oral nutrition including infant formula.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# DEFINITIONS

***Certain words and terms used herein shall be defined as follows:***

**AIR AMBULANCE**

Medical transport by a rotary wing air ambulance or fixed wing air ambulance that is otherwise covered by the Plan.

**AMBULATORY SURGICAL CENTER**

Any private or public establishment with: a) an organized medical staff of Physicians; b) permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient surgical procedures; c) continuous Physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

**ANCILLARY SERVICES**

Items and services provided by an out-of-network provider at an in-network facility that are related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at the in-network facility.

**CALENDAR YEAR**

That period of time commencing at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new Calendar Year.

**CASE MANAGEMENT PROGRAM**

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of in-Hospital treatment.

If, at any point in the progress of a given medical situation, after having considered the opinions of the Covered Person (and/or his legally responsible representatives), the Covered Person's Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**CLAIMS PROCESSOR**

The entity providing consulting services to the Company in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Processor is Allied Benefit Systems, LLC, P. O. Box 211651, Eagan, MN 55121.

**COMPANY**

See the Key Information section at the beginning of this document.

**COSMETIC SURGERY/TREATMENT**

Surgery or treatment that is intended to improve the appearance of a patient or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease (except when necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an accident or trauma, or a disfiguring disease).

**COVERED PERSON / PLAN PARTICIPANT**

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Company employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

**COVERED SERVICES**

These are expenses for certain Hospital and other medical services and supplies for the treatment of Injury or Illness. A detailed list of Covered Services is set forth in this booklet in the section entitled "Schedule of Covered Services and Provisions."

**DEDUCTIBLE/CO-INSURANCE**

The amount of eligible expense incurred in any Calendar Year, which must be satisfied by the Covered Person before benefits are paid. Upon receipt of satisfactory proof that a Covered Person has incurred Covered Services as a result of an Injury or Illness, the Plan, after deducting the Deductible amount shown in the Schedule of Covered Services and Provisions from the Covered Services first incurred during that Calendar Year, will pay benefits at the appropriate Co-Insurance level as shown in the Schedule of Covered Services and Provisions.

**DEPENDENTS**

Spouse of the Employee who is a resident of the same country in which the Employee resides. For additional information, see the Key Information section at the beginning of this document.

Children from birth to the last day of the month they attain age 26. The term *"child"* or *"children"* include children that are specified within the Key Information section at the beginning of this document.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

**DOMESTIC PARTNER**

See the Key Information section at the beginning of this document.

**ELECTIVE SURGICAL PROCEDURE**

Any non-emergency surgical procedure which may be scheduled at a patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions and which is performed while the patient is confined in a Hospital as an Inpatient or in an Ambulatory Surgical Center.

**EMERGENCY ROOM SERVICES**

**"**Emergency Room Services**"** are services provided with respect to a Medical Emergency in an emergency department of a Hospital or an independent freestanding emergency department, to evaluate, stabilize, and treat the patient. Covered Services provided by an out of network provider or facility after a patient has stabilized and as part of Outpatient observation or a required Inpatient or Outpatient stay immediately following and related to the illness or injury for which the Emergency Room Services were needed will also be considered Emergency Room Services unless the following conditions are satisfied:

- The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition. The attending emergency physician's or treating provider's determination is binding on the facility for purposes of this requirement.
- The provider or facility furnishing such additional items and services satisfies the notice and consent criteria prescribed by federal law with respect to such items and services;
- The patient is able to receive the notice and provide consent, as determined by the attending emergency Physician or treating provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable state law.
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed under state law.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

A nonparticipating provider or nonparticipating facility described above will always be considered providing Emergency Room Services with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or nonparticipating emergency facility satisfied the notice and consent requirement described above.

Coverage for Emergency Room Services will be provided consistent with the No Surprises Act and the terms of this Plan.

**EMPLOYEE**

See the Key Information section at the beginning of this document.

**EMPLOYER**

See the Key Information section at the beginning of this document.

**ENROLLMENT DATE**

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

**ESSENTIAL HEALTH BENEFITS**

"Essential Health Benefits" include 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 use 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.

**EXTENDED CARE FACILITY**

An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the elderly, a place for rest, or a place for custodial or educational care.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**FAMILY DEDUCTIBLE**

If the amount of Covered Services incurred by family members and applied toward the Deductible totals the amount shown in the Schedule of Covered Services and Provisions, the Deductible amount shall be waived for all other members of that family unit for that Calendar Year.

**GENDER NEUTRAL WORDING**

A masculine pronoun in this document shall at all times be considered synonymous with a feminine pronoun unless the context indicates otherwise.

**GENETIC INFORMATION**

The term "genetic information" is defined as 1) an individual's own genetic tests, 2) the genetic tests of family members of such individual, and 3) the manifestation of a disease or disorder in family members of such individual. The term “genetic information” also encompasses family medical history. The term "genetic information" additionally extends to genetic information of any fetus carried by a pregnant woman. With respect to an individual or family member utilizing an assisted reproductive technology, genetic information includes the genetic information of any embryo legally held by the individual or family member. The term “genetic information” further extends to dependents and family members defined as first-degree, second-degree, third-degree, or fourth-degree relatives of the individual. The term additionally includes participation in clinical research involving genetic services.

**HOME HEALTH CARE AGENCY**

A public or private agency that is primarily engaged in providing skilled nursing and other therapeutic services and is either (1) licensed or certified as a home health agency by the governing jurisdiction; or (2) certified as a home health agency by Medicare.

**HOSPICE**

A facility established to furnish terminally ill patients a coordinated program of Inpatient and home care of a palliative and supportive nature. A hospice must be approved as meeting established standards, including any legal licensing requirements.

**HOSPITAL**

An institution which meets all of the following requirements; (a) maintains permanent and full-time facilities for bed care of resident patients; (b) has a doctor in regular attendance; (c) continuously provides 24 hour a day nursing services by Registered Nurses (R.N.); (d) is primarily engaged in providing diagnostic and therapeutic services and facilities for medical and surgical care of Injuries or Illnesses on a basis other than a rest home, nursing home, convalescent home, or a home for the aged; (e) maintains facilities on the premises for surgery; (f) is operating lawfully as a Hospital in the jurisdiction where it is located; and (g) is either accredited by the Joint Commission on the Accreditation of Healthcare Organizations or is Medicare approved.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

In addition, the term "Hospital" shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

**HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT**

Only a section, ward or wing within the Hospital which is distinguishable from other Hospital facilities because it (a) is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients, including constant observation and care by a Registered Nurse (R.N.) or other highly trained Hospital personnel, and (b) has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

**HOSPITAL SEMI-PRIVATE**

The room and board charge is not to exceed the semi-private room rate. The difference between the semi-private room rate and the private room rate will be the patient's responsibility and will not apply to, or be affected by, any Out-of-Pocket Maximum provision. However, if 1) a private room is required due to Medical Necessity, or 2) the Hospital only has private rooms, the full private room charge will be considered.

**ILLNESS**

Only non-occupational sickness, disease, mental infirmity, or pregnancy (including surrogacy), all of which require treatment by a Physician.

**INJURY**

Only non-occupational bodily Injury which requires treatment by a Physician.

**INPATIENT**

A Covered Person shall be considered to be an "Inpatient" if he is treated at a Hospital and is confined for 23 or more consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by the patient's Physician as an alternative to Hospital confinement.

**LATE ENROLLMENT**

An enrollment which takes place other than during the first period during which an individual was eligible for coverage, or other than during a period of Special Enrollment or Open Enrollment. See the Key Information section at the beginning of this document for applicability.

**LIFETIME**

Shall mean, "while covered under the Plan". Under no circumstances will the word "Lifetime" mean "during the lifetime of the Covered Person".

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**MEDICAL EMERGENCY**

A **"**Medical Emergency**"** is defined as a medical condition, including a Mental/Nervous or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

**MEDICALLY NECESSARY**

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

**MEDICARE DRG OR APC REIMBURSEMENT RATE**

The inpatient and outpatient reimbursement rates set by Centers for Medicare and Medicaid Services (CMS).

**MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES**

Services for diagnoses that are listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered.

**NAMED FIDUCIARY**

The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Employer, who is the sponsor of this Plan.

In exercising its fiduciary responsibilities, the Employer shall have sole, full and final discretionary authority to determine eligibility for benefits, review denied claims for benefits, construe and interpret all Plan provisions, construe disputed Plan terms, select managed care options, determine all questions of fact and law arising under this Plan, and to administer the Plan's subrogation and reimbursement rights. The Employer shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**OPEN ENROLLMENT**

Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer. See the Key Information section at the beginning of this document for applicability, as well as Your Employer for details.

**OUT-OF-NETWORK RATE**

With regard to services that are subject to balance billing protections (see the "Out-of-Network Benefits" section for more detail), the Out-of-Network Rate is the amount used to calculate the benefit payable to the out of network provider for Covered Services. The Out-of-Network Rate will equal (i) the Recognized Amount, (ii) an amount agreed to by the Plan and the provider, (iii) or the amount determined payable in accordance with the independent dispute resolution process set forth in section 716(c) or 717(b) of ERISA.

**OUT-OF-POCKET MAXIMUM**

The "Out-of-Pocket Maximum" is the total amount of co-pays, co-insurance and deductibles for which the Covered Person or covered family is responsible during the course of a Calendar Year. These amounts are shown in the "Schedule of Covered Services and Provisions," along with expenses not applicable towards the Out-of-Pocket maximum. Once this amount has been reached, 100% level of benefits applies for the remainder of that Calendar Year.

**OUTPATIENT**

A Covered Person shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 23 consecutive hours.

**PHYSICIAN**

A Physician who is duly qualified and licensed and/or certified by the state in which he is resident to practice medicine, perform surgery and to prescribe drugs, or who is licensed to practice as a dentist, podiatrist, chiropractor, psychologist, social worker or practitioner of healing arts, and who is practicing within the scope of his license and/or certification.

**PLACEMENT FOR ADOPTION**

The assumption and retention of a legal obligation for total or partial support in anticipation of adoption.

**PLAN**

The benefits and provisions for payment of same as described herein are the Employer Plan as described in the Key Information section at the beginning of this document. This is a group health plan.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**PLAN ADMINISTRATOR**
The entity responsible for the day-to-day functions and overall management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services. The Plan Administrator is the Company.

**PLAN YEAR**
The 12-month period defined in the Key Information section at the beginning of this document. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section.

**QUALIFIED MEDICAL CHILD SUPPORT ORDER**

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If Your employer determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO, and Your current plan offers dependent coverage, You will be required to provide coverage for any child(ren) named in the QMCSO. If You do not enroll the child(ren), Your employer must enroll the child(ren) upon application from Your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from Your pay Your share of the cost of such coverage. You may not drop coverage for the child(ren) unless You submit written evidence to Your employer that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). ERISA preemption of state laws does not apply to Qualified Medical Child Support Orders and provisions of state laws requiring medical child support. Group health plans may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning "QMCSO" procedures are available from the Plan Administrator at no charge upon request.

**REASONABLE/REASONABLENESS**

"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or charges for services or supplies, which are necessary for the care and treatment of Illness or Injury. Determination that charges or services/supplies 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/or the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination may consider, but not be limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, services, supplies and/or charges must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether services, supplies and/or charges are Reasonable based upon information presented to the Plan Administrator.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

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

**RECOGNIZED AMOUNT**

For purposes of Covered Services that are subject to balance billing protections (see the "Out-of-Network Benefits" section for more details), the Recognized Amount is the amount used to calculate the Covered Person's cost share for such services. The Recognized Amount is typically the lesser of the billed charge or the qualifying payment amount. The methodology for determining the qualifying payment amount is set by federal regulations at 29 CFR 2590.716-6, and is adjusted from time to time*.

**RECONSTRUCTIVE BREAST SURGERY COVERAGE**

Medical benefits under the Plan will be administered according to the terms of the Women's Health and Cancer Rights Act of 1998. The Plan will provide to Covered Persons who are receiving Plan benefits in connection with such mastectomy coverage for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. The coverage will be subject to the terms of the Plan established for other coverage under the Plan, including the annual deductible and coinsurance provisions.

**RETIREE**

See the Key Information section at the beginning of this document.

**SECOND SURGICAL OPINION**

Shall mean a written statement on the necessity for the performance of a covered surgical procedure. This Second Surgical Opinion must be given by a board-certified specialist who, by the nature of the Physician's specialty, qualifies the Physician to consider the surgical procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the surgery.

**SPECIAL ENROLLMENT**

An enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See "Eligibility" section for details.

*In some situations, different rules will apply and the Recognized Amount, as defined by federal rules at 29 CFR 2590.2590.716-3, will be used instead. The Recognized Amount takes into account whether a particular state has adopted an all-payer model agreement, or whether state law applies for setting fees. If neither an all-payer model agreement nor state law legally applies, the Recognized Amount would, in most cases, be the lesser of the qualifying payment amount or the amount the non-network provider actually billed.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**USUAL AND CUSTOMARY**

"Usual and Customary" (U&C) shall mean Covered Services which are identified by the Plan Administrator, taking into consideration the charge(s) which the provider most frequently bills the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the prevailing range of charges billed in the same "area" by providers of similar training and experience for the service or supply, and/or 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, service, or supply for which a specific charge is made. To be Usual and Customary, the charge must be in compliance with the Plan Administrator's policies and procedures relating to 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 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 Covered Person by a provider of services or supplies. 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.

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, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

**WAITING PERIOD**

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period.

**YOU, YOUR, YOURSELF**

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Company employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# ELIGIBILITY

## WHO IS ELIGIBLE

See the Key Information section at the beginning of this document.

## NON-DISCRIMINATION

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

## EMPLOYEE COVERAGE

For date of eligibility, please see the Key Information section at the beginning of this document. Providing a new employee is actively at work on at least the first day of employment, the Plan will not exclude absences from work due to health-related reasons from credit towards the waiting period, if applicable, as referenced in the Key Information section.

## DEPENDENT COVERAGE

Each Dependent of the eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:

1. The date the Employee is eligible; or
2. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

## INDIVIDUAL EFFECTIVE DATE

All persons become covered, as they become eligible subject to the following:

1. All Employees, who are eligible Employees, shall be covered on the day they become eligible, as discussed in the Key Information section at the beginning of this document.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will begin from the date of Placement for Adoption. Coverage for a stepchild or foster

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

child will begin from the date the child meets the definition of "Dependent." With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 30 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 30 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date that the child meets the definition of "Dependent."

**OPEN ENROLLMENT**

See the Key Information section at the beginning of this document for applicability.

**LATE ENROLLMENT**

See the Key Information section at the beginning of this document for applicability.

**SPECIAL ENROLLMENT**

The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a late enrollee.

An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and lose that coverage. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance (CHIP) program with respect to this Plan.

If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended. Loss of eligibility includes a loss of coverage due to:

- divorce;
- legal separation;
- death;
- termination of employment, or reduction in hours of employment;

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals;
- the Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the employee or dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 30 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

**TERMINATION OF COVERAGE**

See the Key Information section at the beginning of this document for details.

# EMPLOYER POLICIES AND PROCEDURES

Except as required under the Americans with Disabilities Act, the Family and Medical Leave Act, or the Uniformed Services Employment and Reemployment Rights Act, or applicable state leave laws such as CFRA in California and OFLA in Oregon, the Employer's policies and procedures regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified disability, leave of absence, furlough, reinstatement, hire or rehire. Whether an Employee averages the requisite hours of service to be eligible for coverage shall be determined in accordance with the policies and procedures of the Employer.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

The Plan may not 1) deny a Qualified Individual participation in an Approved Clinical Trial, 2) deny (or limit or impose additional conditions on) coverage of Routine Patient Costs for items and services furnished in connection with the Approved Clinical Trial, or 3) discriminate against the Qualified Individual based on his/her participation in the Approved Clinical Trial. However, if the Plan has a network of providers and one or more network providers is participating in an Approved Clinical Trial, the Qualified Individual must participate in the Approved Clinical Trial through such network provider if the provider will accept the Qualified Individual as a participant in the trial. This requirement to use network providers will not apply to a Qualified Individual participating in an Approved Clinical Trial that is conducted outside the state in which the Qualified Individual resides (unless the Plan does not otherwise provide out-of-network coverage generally).

The following definitions are applicable under this provision:

**Qualified Individual**

A Covered Person who meets the following conditions:

A. The Covered Person is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition, and

B. Either:

- The referring health care professional is a participating health care provider and has concluded that the Covered Person's participation in such trial would be appropriate, or
- The Covered Person provides medical and scientific information establishing that the Covered Person's participation in such trial would be appropriate.

**Approved Clinical Trial**

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, or Mental/Nervous and Substance Use Disorder Services, and is described in any of the following subparagraphs:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    1. The National Institutes of Health.
    2. The Centers for Disease Control and Prevention.
    3. The Agency for Health Care Research and Quality.
    4. The Centers for Medicare & Medicaid Services.
    5. A cooperative group or center of any of the entities described in clauses 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
7. Any of the following entities in clauses 7a. through 7c. below if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    a. The Department of Veterans Affairs.
    b. The Department of Defense.
    c. The Department of Energy.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

**Routine Patient Costs**

All items and services consistent with the coverage provided by the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. However, Routine Patient Costs do not include:

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

**Life-Threatening Disease or Condition**

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# NETWORK BENEFITS

Your Plan contains enhanced benefits through network providers. The name of the organization associated with these network providers is indicated on the front of Your ID card, along with instructions regarding where to file medical claims. Benefits are generally paid at a higher level when using network Hospitals and network Physicians than when using non-network providers. Please refer to the Schedule of Covered Services and Provisions for benefits payable according to type of provider used.

A Physician or Hospital's status within Your network can change. In order to access the most up-to-date list of in-network providers, visit alliedbenefit.com or call the customer service number on Your ID card.

**When Your Provider Leaves the Network**
If Your provider or facility is leaving/has left the Plan's network due to nonrenewal or expiration of the contract, the Plan will notify You. You, in turn, will need to notify the Plan if You require continuing transitional care with that provider or facility for certain serious or complex conditions, pregnancy, terminal illness, scheduled non-elective surgical care, or if You are undergoing Inpatient or institutional care. You may have a right to elect to continue transitional treatment and still be covered by the Plan under the same terms and conditions that existed when the provider or facility was part of the Plan's network. Such coverage would be temporary, up to a maximum of 90 days.

A Covered Person has a free choice of any provider for medical care. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan. Please see the "Out-of-Network Benefits" section for an explanation of notice and consent requirements for non-network providers.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# OUT-OF-NETWORK BENEFITS

This Plan is designed for You to receive maximum benefits through its network Hospitals and network Physicians. As set forth in the Schedule of Covered Services and Provisions, benefits are payable at a different level for non-network providers, and the Plan Administrator, in its sole discretion, uses various methodologies for determining the Plan's reimbursable amount for Covered Services from non-network providers. When You choose a non-network provider, You are responsible for paying, directly to the non-network provider, any difference between the reimbursable amount and the amount the provider bills You. This is called "balance billing."

**BALANCE BILLING PROTECTIONS**

For Covered Services received on or after January 1, 2022, new federal rules apply to the following services provided by an out of network provider or facility to prevent You from being balanced billed:

- *Emergency Room Services*.
- *Air Ambulance*.
- *Non-Emergency Care* when provided by a non-network provider at certain in-network facilities (i.e., a Hospital, a Hospital Outpatient department, a critical access Hospital, an Ambulatory Surgical Center, and any other facility specified by the Secretary of HHS) for the categories of service listed below:
    - Ancillary Services (see the Definitions section);
    - Non-Ancillary Services, if the non-network provider has not given proper notice and You've not given proper consent;

For the services above, the most a provider may bill You is Your Plan's in-network cost-sharing amount (co-pay, Coinsurance and/or Deductible) that is based on the Recognized Amount for such services.

Your out-of-pocket amounts for the above mentioned services will be applied to Your in-network limits (e.g. deduction and/or Out-of-Pocket Maximum).

A note about Notice and Consent (where required). In certain situations described above, You can still be balance billed by a non-network provider or facility so long as You receive proper notice, and You (or Your authorized representative's) consent to waive Your rights to balance billing protections prior to the Covered Service.

If You believe You have been wrongly billed, You may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit Your question or a complaint. You can also submit a complaint online at:
https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

Visit https://www.cms.gov/nosurprises for more information about Your rights under federal law.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# PROCEDURES FOR FILING CLAIMS

Remember to Pre-Certify by calling the toll-free number shown on Your ID card if required by Your Plan.

**KEY POINTS TO REMEMBER**

The claims filing address You must use for filing all medical claims is shown on Your ID card.

1. Each bill should be itemized as to services, show payment status, and include the name of the patient, the Employee's social security number or unique identification number ("UID"), and the name and/or group number of the Employer.
2. It is Your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
3. All charges, and corresponding requested documentation, must be submitted within the time frame specified in the Schedule of Covered Services and Provisions. Failure to do so will result in the denial of the charges.
4. From time to time, additional information may be requested to process Your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, accident details, police reports, etc. must be submitted by You or Your provider(s) when requested within the time frame specified in the Schedule of Covered Services and Provisions. Your failure to do so will result in the denial of the claim.
5. Only clean claims will be adjudicated by the Plan. A clean claim is one that is complete and accurate, does not require further information for processing from the provider, patient, or any other person or entity, and leaves no issues regarding the Plan's responsibility for payment.
6. Urgent care claims: The Plan will defer to the attending provider regarding the decision as to whether the claim constitutes an urgent care claim. Clean urgent care claims will be determined by the Plan as soon as possible (taking into account medical exigencies), but not later than 72 hours after receipt of the claim. For incomplete or incorrectly filed urgent care claims, You will be notified of the proper procedures to follow as soon as possible but no later than 24 hours after receipt of the claim.

**FILING A HOSPITAL CLAIM**

When a Covered Person is admitted as an Inpatient or is treated as an Outpatient, secure an itemized Hospital bill, including an admitting diagnosis. Check Your bill for any possible errors and then submit the charges as indicated above.

Always retain a copy of the hospital bill for Your records.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**MISCELLANEOUS CLAIMS FILING CONSIDERATIONS**

It is necessary to keep separate records of Your expenses with respect to each of Your Dependents and Yourself. The following items are important and should be carefully kept to be submitted with Your claim:

1. All Physician's bills should show the following:
    a. Name of patient and adequate membership information
    b. Dates and charges for services, and payment status of each
    c. Types of service rendered and procedure codes
    d. Diagnosis information

2. Prescription drug expenses should show the following:
    a. Name of patient and adequate membership information
    b. Prescription number and name of drug
    c. Cost of the drug and date of purchase. Cash register receipts and canceled checks cannot be accepted for payment.
    d. Generic Drugs should be indicated on the drug bill

3. Bills for all other covered medical charges, such as for ambulance service, durable medical equipment, etc. should show the following:
    a. Name of patient and adequate membership information
    b. Date of service
    c. Charge and description of each service/item
    d. Diagnosis information

Always retain a copy of the bill for Your records.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# THIS PLAN AND MEDICARE

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. If the Employee is still actively at work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
5. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# GENERAL PROVISIONS

## ADMINISTRATION OF THE PLAN

The Plan is administered through the Office of the Company. The Company has retained the services of an independent Claims Processor experienced in claims processing. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section at the beginning of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator at the address specified in the Key Information section at the beginning of this document.

## APPEALING A CLAIM

### CLAIMS PROCEDURES

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. A rescission is 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. An Adverse Benefit Determination is subject to the provisions detailed below.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.
- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal, the contact information for the Employee Benefits Security Administration (1-866-444-EBSA (3272)) to assist individuals with the first level claim and appeal process and second level (external) appeal process if applicable (see below), and a statement of claimant's right to bring a civil action under Section 502(a) of ERISA following a determination on appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

**FIRST LEVEL APPEALS PROCEDURE**

If You receive an Adverse Benefit Determination, You or Your authorized representative may appeal the determination by filing a written application with the Plan Administrator. In appealing an Adverse Benefit Determination, the Plan Administrator will provide You or Your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

**A first level appeal must be filed within 180 days after the Adverse Benefit Determination is received.** The Plan Administrator will notify You or Your authorized representative of its determination within 60 days after receipt of an appeal.

The Plan Administrator's determination:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.
- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Will contain a statement of Your right to bring an action under Section 502(a) of ERISA if a second level (external) review is inapplicable.
- Will contain a description of the Plan's second level (external) review process (applicable solely where the Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act), including information on how to initiate a second level appeal, and the contact information for the Employee Benefits Security Administration to assist individuals with the second level review process (1-866-444-EBSA (3272)), as well as a statement of Your right to bring a civil action under Section 502(a) of ERISA following the determination of the external review.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit 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.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the first level claims and appeals process with respect to a claim, You are deemed to have exhausted the first level claims and appeals process (unless the Plan's failure to strictly adhere to these requirements is 1) *de minimis*, 2) non-prejudicial, 3) attributable to good cause or matters beyond the Plan's control, 4) in the context of an ongoing good faith exchange of information, and 5) not reflective of a pattern or practice of non-compliance). Accordingly, upon such a failure, You may initiate a second level (external) review (see below) or, if not applicable, pursue any available remedies under applicable law.

To the extent the Plan contends that it did not commit a procedural violation based on the five criteria referenced immediately above, You will be entitled, upon written request, to an explanation of the Plan's basis for such an assertion (to be provided within ten days), so that You can make an informed judgment about whether to seek immediate review from an external reviewer or, if not applicable, a court of law. Finally, if the external reviewer or the court of law (as applicable) rejects Your request for immediate review on the basis that the Plan did not engage in a violation, You have the right to resubmit and pursue the first level claims and appeals process.

If the Plan denies Your first level appeal, in whole or in part, and You choose to bring a civil action, such action must be filed within 365 days of the date of the Plan's denial of Your first level appeal. This 365 day time period, however, will be temporarily suspended to the extent You are entitled to file a second level (external) appeal (see below) and do in fact file such an appeal. Under such circumstances, this 365 day time period will be suspended from the date You submit a request for a second level (external) appeal that is both complete and eligible until the date of the Independent Review Organization's decision (see below).

**SECOND LEVEL (EXTERNAL) APPEALS PROCEDURE**

If the Plan denies Your first level appeal, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or Your authorized representative may file a second level (external) appeal of the Final Internal Adverse Benefit Determination where the Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act. To file a second level appeal, You must file a written application with the Plan Administrator.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**A second level appeal must be filed within 4 months after the Final Internal Adverse Benefit Determination is received.** If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Plan reserves the right to charge a nominal filing fee, as allowed by applicable law.

**Preliminary review**. Within 5 business days following the date of receipt of the second level (external) review request, the Plan must complete a preliminary review of the request to determine whether:

a. The claimant is or was covered under the Plan at the time the health care service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care service was provided;

b. The Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act;

c. The claimant has exhausted the Plan's first level appeal process; and

d. The claimant has provided all the information and forms required to process a second level review.

Within one business day after completion of the preliminary review, the Plan must issue a notification in writing to the claimant. If the request is complete but not eligible for a second level review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the Plan must allow a claimant to perfect the request for the second level review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

**Referral to Independent Review Organization**. The Plan must assign an independent review organization ("IRO") to conduct the second level (external) review. The assigned IRO will timely notify the claimant in writing of the acceptance for the second level review. This notice will include a statement that the claimant may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the second level review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within 5 business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Final Internal Adverse Benefit Determination. If the Plan fails to timely provide the documents and information, the IRO may terminate the second level review and make a decision to reverse the Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

Upon receipt of any information submitted by the claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Final Internal Adverse Benefit Determination that is the subject of the second level review. The second level review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

making such a decision, the Plan must provide written notice of its decision to the claimant and the IRO. The IRO must terminate the second level review upon receipt of the notice from the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim without deference to the Plan and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider the following additional information:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from other health care professionals and other documents submitted by the Plan, claimant or claimant's treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, including evidence-based standards and other guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless such criteria are inconsistent with the terms of the Plan or applicable law; and
- The opinion of the IRO's clinical reviewer(s) to the extent the information or documents are available and the clinical reviewer(s) considers appropriate;

The IRO must provide written notice of its second level review decision within 45 days after it receives the request for the second level review. The notice must be provided to both the claimant and the Plan, and must include the following:

- A general description of the reason for the request for the review with enough information to identify the claim, and reason for the Final Internal Adverse Benefit Determination;
- The date the IRO received the assignment to conduct the second level review;
- The date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards used;
- A statement that the determination is binding, except to the extent other legal remedies may be available under Federal or state law to the Plan or claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

The IRO must maintain records of all claims and notices associated with the second level review process for 6 years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

**Reversal of the Plan's decision**. Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim.

For questions about Your appeal rights or for assistance, You can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

**ASSIGNMENT OF BENEFITS**

An arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits. Plan Participants cannot assign, pledge, borrow against or otherwise promise any benefits payable under the Plan before receipt of the benefit. However, benefits will be provided to a Participant's qualified dependent if required by a Qualified Medical Child Support Order or National Medical Support Notice. In addition, subject to the written direction of a Participant, all or a portion of benefits provided by the Plan may, at the option of the Plan and unless a Participant requests otherwise in writing, be paid directly to the person rendering such service. The payment of benefits directly to a provider of services, if any, is done as a convenience to the Plan Participant and does not constitute an assignment of rights or benefits under the Plan. Providers of services are not, and shall not be construed as, either "Participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants and beneficiaries under any circumstances. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Employer to the extent of such payment.

**CLAIM AUDIT**

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

**COMPLIANCE**

The Plan shall comply with all federally mandated benefit laws and regulations pertaining to employee benefit plans. The intent of the Plan is to assure full compliance with all appropriate federal laws, rules and regulations and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional. The Claims Processor shall be fully discharged from liability under this Plan.

**CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS**

Same as Employer.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**CONTRIBUTIONS**

The benefits provided under the terms of this Plan are purchased through Employer contributions. At the discretion of the Company, Employees may be required to contribute on a payroll deduction basis.

**ERISA AMENDMENTS**

Any provision of this Plan that is in conflict with ERISA, which governs this Plan, shall be deemed amended to conform to the minimum requirements of the law.

**FUNDING**

This Plan is a Company sponsored self-funded reimbursement program for the benefits described in the Key Information section at the beginning of this document.

**LIENS**

To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

**NO WAIVER**

A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

**PLAN IS NOT A CONTRACT**

The Plan shall not be deemed to constitute a contract between the Company and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

**PLAN AMENDMENT, MODIFICATION OR TERMINATION**

The Company reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Company. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

**PROHIBITION ON RESCISSION**

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

## REIMBURSEMENT AND SUBROGATION PROVISIONS

### PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Illness, Injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, 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 "Coverage").

However, such payment of benefits by the Plan shall be made only if the Covered Person first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

The Covered Person (including his attorney, and/or legal guardian of a covered minor or incapacitated individual) 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 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 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. Further, by accepting benefits, the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person settles, recovers, or is reimbursed by any 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 (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who 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, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

### SUBROGATION

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,

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as applied to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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 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.

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.

**RIGHT OF REIMBURSEMENT**

The Plan shall have the specific right of first recovery ("reimbursement"), and as such, 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 equitable and/or legal theory, without regard to whether the Covered Person is fully compensated by his 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

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

as including medical, disability, or other expenses. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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, express written consent of the Plan.

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.

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.

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, injury, disease or disability.

**COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS**

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Covered Person understands that he/she is required to:

a) notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

c) in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

d) hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

To the extent the Covered Person disputes his/her obligation to the Plan under this section, the Covered Person or any of his/her agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from his/her general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

**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(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(s), 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.

**WRONGFUL DEATH**

In the event that the Covered Person dies as a result of his injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

**OBLIGATIONS**

It is the Covered Person's 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 Illness, Injury, or disability, 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, including providing to the Plan an executed reimbursement agreement;

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 Covered Person may have against any responsible party or Coverage.

If the Covered Person and/or his 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

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

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's cooperation or adherence to these terms.

**OFFSET**

Failure by the Covered Person and/or his 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 obligation.

**MINOR STATUS**

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 estate insofar as these subrogation and reimbursement provisions are concerned.

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.

**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.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

**RIGHTS OF RECOVERY**

Whenever payments have been made by the Plan which are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Claims Processor or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**SEVERABILITY**

Should any provision of this Summary Plan Description be declared invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining portions of the Summary Plan Description. Any remaining portions shall remain in full force and effect, as if this Summary Plan Description did not contain the invalid or illegal provision.

**SUBMISSION OF CLAIM**

All charges, and corresponding requested documentation, must be submitted by the date specified in the Schedule of Covered Services and Provisions. Failure to do so will result in the denial of the charges.

**SUMMARY OF MATERIAL MODIFICATIONS**

Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in Covered Services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

**SUMMARY PLAN DESCRIPTION**

The Company will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is intended to satisfy the requirement for both a Summary Plan Description and Plan Description as specified under ERISA.

**SYSTEM FOR PROCESSING CLAIMS**

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, Reasonable and/or Usual and Customary limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

**TYPE OF ADMINISTRATION**

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Processor to process claims and provide consulting services and ministerial functions.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. See Schedule of Covered Services and Provisions to determine the type of Coordination of Benefits this Plan provides.

To coordinate benefits, it is necessary to determine in what order the benefits of various Plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

   If the parent with custody has not remarried:

   a) The plan of the parent with custody is primary.
   b) The plan of the parent without custody is secondary.

   If the parent with custody has remarried:

   a) The plan of the parent with custody is primary.
   b) The plan of the stepparent with custody is secondary.
   c) The plan of the parent without custody is tertiary (third).

   There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.
5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

To the extent that the Plan would be secondary to Medicare, if a Covered Person is eligible for Medicare Part A and/or Part B and does not elect to enroll in such Medicare coverage, then Plan benefits will be coordinated based on an estimate of what Medicare would have paid, regardless of whether benefits are actually received from Medicare.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Any other “plan” means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee, Employee benefit association, government agency or professional association; or any homeowner’s policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any individual or non-group health coverage, of which the Plan Administrator is actually aware, including but not limited to a plan or policy purchased or made available through a state or federally managed Health Insurance Marketplace; or any coverage provided by a licensed Health Maintenance Organization (HMO); or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term “plan” shall also mean any mandatory “no-fault” automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident; and any other payment received under any automobile policy.

To administer this provision, the Company has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party, when the Company should have made the payment.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# COMPLIANCE REGULATIONS

## STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain pre-certification. For information on pre-certification, contact Your Plan Administrator.

## SOURCE OF INJURY RESTRICTIONS

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

## WELLNESS VS. RISK FACTORS

The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

## FAMILY MEDICAL LEAVE ACT (FMLA)

### The following applies to companies with 50 or more employees

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Company that the Covered Person does not intend to return to work at the end of the FMLA leave.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

The Covered Person may choose not to retain health coverage during the FMLA leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA leave.)

**MILITARY LEAVES**

If You are absent from work due to military service, You may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date You are required to apply for or return to active employment with Your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if You are absent for 30 days or less, Your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that You had not fully completed any required waiting period prior to the start of military service.

**GENETIC INFORMATION**

The Plan may not adjust premium or contribution amounts for those covered under the Plan on the basis of genetic information. The Plan may also not request, require or purchase genetic information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no genetic information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

## INTRODUCTION

This notice contains important information about Your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You and other members of Your family when group health coverage would otherwise end. For more information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

## WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a “qualifying event”. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You're an employee, You'll become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

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

If You're the spouse of an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

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

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**WHEN IS COBRA COVERAGE AVAILABLE?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.**

**HOW IS COBRA COVERAGE PROVIDED?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18 month period of COBRA continuation coverage can be extended.

**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 notify the Plan Administrator in a timely fashion, 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. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

**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 the Plan is properly notified about 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.

**ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?**

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.HealthCare.gov.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

You should compare Your other coverage options with COBRA continuation coverage and choose the coverage that is best for You. For example, if You move to other coverage You may pay more out of pocket than You would under COBRA because the new coverage may impose a new deductible.

When You lose job-based health coverage, it's important that You choose carefully between COBRA continuation coverage and other coverage options, because once You've made Your choice, it can be difficult or impossible to switch to another coverage option.

**WHAT IS THE HEALTH INSURANCE MARKETPLACE?**

The Marketplace allows You to find and compare private health insurance options. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums and cost-sharing reductions (amounts that lower Your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Through the Marketplace You'll also learn if You qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for Your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage.

**WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?**

You always have 60 days from the time You lose Your job-based coverage to enroll in the Marketplace. That is because losing Your job-based health coverage is a "special enrollment" event. **After 60 days Your special enrollment period will end and You may not be able to enroll, so You should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what You need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

**IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?**

If You sign up for COBRA continuation coverage, You can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end Your COBRA continuation coverage early and switch to a Marketplace plan if You have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if You terminate Your COBRA continuation coverage early without another qualifying event, You'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Once You've exhausted Your COBRA continuation coverage and the coverage expires, You'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If You sign up for Marketplace coverage instead of COBRA continuation coverage, You cannot switch to COBRA continuation coverage under any circumstances.

**WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?**

When considering Your options for health coverage, You may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If You're currently getting care or treatment for a condition, a change in Your health coverage may affect Your access to a particular health care provider. You may want to check to see if Your current health care providers participate in a network as You consider options for health coverage.
- Drug Formularies: If You're currently taking medication, a change in Your health coverage may affect Your costs for medication – and in some cases, Your medication may not be covered by another plan. You may want to check to see if Your current medications are listed in drug formularies for other health coverage.
- Severance payments: If You lost Your job and got a severance package from Your former employer, Your former employer may have offered to pay some or all of Your COBRA payments for a period of time. In this scenario, You may want to contact the Department of Labor at 1-866-444-3272 to discuss Your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if You move to another area of the country, You may not be able to use Your benefits. You may want to see if Your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, You probably pay copayments, deductibles, coinsurance, or other amounts as You use Your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

**IF YOU HAVE QUESTIONS**

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under the Employee Retirement Income Security Act (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) in Your area 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.) For more information about the Marketplace, visit www.HealthCare.gov.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

In order to protect Your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You sent to the Plan Administrator.

**PLAN CONTACT INFORMATION**

If You have any questions regarding COBRA Continuation Coverage under the Plan, please contact Your Plan Administrator.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# ERISA RIGHTS SECTION

As a Plan Participant, You are entitled to certain rights and protection 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 the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Services Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**CONTINUE GROUP HEALTH PLAN COVERAGE**

Continue health care 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 may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

**PRUDENT ACTIONS BY PLAN FIDUCIARIES**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the 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, Your union, 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 benefit is denied or ignored, in whole or in part, or if Your coverage was rescinded, You have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

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 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, or if Your coverage was rescinded, You may file suit in a state or Federal court, subject to the procedures discussed in the Section "APPEALING A CLAIM" under "GENERAL PROVISIONS." In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's 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.

**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 Services Administration (EBSA), U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Services 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 EBSA.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS")

## ISSUED PURSUANT TO

**The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA")**

**1. Disclosure of Summary Health Information to the Plan Sponsor**

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

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

**2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes**

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

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);

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

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

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

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

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

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

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

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

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

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

    i. The access to and use of PHI by the individuals described in the Key Information section at the beginning of this document shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

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

"Plan Administration" functions are activities that would meet the definitions of treatment, payment and health care operations. "Plan Administration" functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, medical necessity reviews, certain appeal determinations, utilization review, case management and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

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

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**3. Disclosure of Certain Enrollment Information to the Plan Sponsor**

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

**4. Other Disclosures and Uses of PHI**

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

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT COVERED PERSONS MAY BE USED AND DISCLOSED AND HOW COVERED PERSONS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan's legal obligations concerning a Covered Person's protected health information and describes a Covered Person's rights to access, amend and manage that protected health information.

Protected health information ("PHI") is individually identifiable health information, including demographic information, collected from a Covered Person or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Person's past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Person; or (3) the past, present or future payment for the provision of health care to a Covered Person.

This Notice has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document:

**THE PLAN'S RESPONSIBILITIES**

The Plan is required by law to maintain the privacy of a Covered Person's PHI. The Plan is obligated to provide the Covered Person with a copy of this Notice of the Plan's legal duties and of its privacy practices with respect to the Covered Person's PHI, abide by the terms of the Notice that is currently in effect, and notify the Covered Person in the event of a breach of the Covered Person's unsecured PHI. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

**PERMISSIBLE USES AND DISCLOSURES OF PHI**

The following is a description of how the Plan is most likely to use and/or disclose a Covered Person's PHI.

**TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

**TREATMENT**

The Plan will use or disclose PHI so that a Covered Person may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between one or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's primary care physician so that the specialist may request medical records from that primary care physician.

**PAYMENT**

The Plan will use or disclose PHI to pay claims for services provided to a Covered Person and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

**HEALTH CARE OPERATIONS**

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

**POTENTIAL IMPACT OF STATE LAW**

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

**OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI**

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

**REQUIRED BY LAW**

The Plan may use or disclose PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

**PUBLIC HEALTH ACTIVITIES**

The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

**HEALTH OVERSIGHT ACTIVITIES**

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

**ABUSE OR NEGLECT**

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Covered Person's PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**LEGAL PROCEEDINGS**

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

**LAW ENFORCEMENT**

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

**CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION ORGANIZATIONS**

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

**RESEARCH**

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

**TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY**

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

**MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES**

Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

**INMATES**

If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Person; (2) the Covered Person's health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

**WORKERS' COMPENSATION**

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

**EMERGENCY SITUATIONS**

The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

**FUNDRAISING ACTIVITIES**

The Plan may use or disclose the PHI of a Covered Person for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does contact the Covered Person for fundraising activities, the Plan will give the Covered Person the opportunity to opt-out, or stop, receiving such communications in the future.

**GROUP HEALTH PLAN DISCLOSURES**

The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Covered Person. The Plan can disclose the PHI of the Covered Person to that entity if that entity has contracted with the Plan to administer the Covered Person's health care program on its behalf.

**UNDERWRITING PURPOSES**

The Plan may use or disclose the PHI of a Covered Person for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Covered Person for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI of the Covered Person that is genetic information.

**OTHERS INVOLVED IN YOUR HEALTH CARE**

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

## REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

### DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

### DISCLOSURES TO COVERED PERSONS

The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: (1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

### BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

**OTHER COVERED ENTITIES**

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

**PLAN SPONSOR**

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

**USES AND DISCLOSURES OF PHI THAT REQUIRE A COVERED PERSON'S AUTHORIZATION**

**SALE OF PHI**

The Plan will request the written authorization of a Covered Person before the Plan makes any disclosure that is deemed a sale of the Covered Person's PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

**MARKETING**

The Plan will request the written authorization of a Covered Person to use or disclose the Covered Person's PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person or when the Plan provides promotional gifts of nominal value.

**PSYCHOTHERAPY NOTES**

The Plan will request the written authorization of a Covered Person to use or disclose any of the Covered Person's psychotherapy notes that the Plan may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Person's written authorization. If the Covered Person provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

## A COVERED PERSON'S RIGHTS

The following is a description of a Covered Person's rights with respect to PHI:

### RIGHT TO REQUEST A RESTRICTION

A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations. The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send the request when the Covered Person's call is received. In this request, it is important that the Covered Person states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

### RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Covered Person believes that a disclosure of all or part of his PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

The Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

(2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document as soon as the Covered Person determines the need to restrict disclosures of his PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

**RIGHT TO INSPECT AND COPY**

A Covered Person has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a request by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Person

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. If a Covered Person is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A licensed health care professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

**RIGHT TO AMEND**

If a Covered Person believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Person may request that the Plan amend such information by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. Additionally, this request should include the reason the amendment is necessary. It is important that the Covered Person direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Person has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

**RIGHT OF AN ACCOUNTING**

The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Covered Person may request an accounting by submitting a request in writing to the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

Covered Person direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

**RIGHT TO A COPY OF THIS NOTICE**

The Covered Person has the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. If You receive this Notice on the Plan's website or by electronic mail, You also are entitled to request a paper copy of this Notice.

**COMPLAINTS**

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A copy of a complaint form is available from this contact office.

A Covered Person also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Covered Person became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

Docusign Envelope ID: 54994AD8-2FC8-4616-9ABB-E09E3B6C2918

# STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "SECURITY STANDARDS")

## 1. DEFINITIONS

a. The term "Electronic Protected Health Information" ("EPHI") has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.

b. The term "Security Incidents" has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

## 2. PLAN SPONSOR OBLIGATIONS

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and

d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

   i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and

   ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# Plan Endorsement #26-SP

| | | | |
|---|---|---|---|
| GROUP # | A22100 | | |
| EFFECTIVE DATE | January 1, 2026 | | |
| EMPLOYER ID# | 20-3284366 | PLAN #s | 501 |
| NAME OF PLAN | Forest River, Inc. Employee Benefits Plan | | |
| TYPE OF PLAN | $5,000 Plan | | |

The following wording is hereby added to the Plan:

Forest River, Inc. of Elkhart, Indiana hereby establishes a plan for payment of certain expenses for the benefit of its eligible employees to be known as Forest River, Inc. Employee Benefits Plan. The attached document serves as the summary plan description, plan description and plan document for the Plan.

Forest River, Inc. has caused this Plan to take effect as of 12:01 A.M. Eastern Time on January 1, 2026 at Elkhart, Indiana.

APPROVED AND ATTESTED:

BY Signed by: Dave Besinger 2A80C4A9E28D4A4... TITLE VP HR

DATE 09/10/2025 | 10:29:32 AM EDT

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# FOREST RIVER, INC.

900 County Road 1 North
Elkhart, IN 46514
Phone: (574) 389-4600

# $5,000 Plan

***This booklet describes the Medical benefits for Eligible Employees of Forest River, Inc.***

Information Applicable to Plan 501

Employer Identification Number
20-3284366

**The Benefits In This Booklet Are Effective**
**January 1, 2026**

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# TABLE OF CONTENTS

KEY INFORMATION ..... 1
PRE-CERTIFICATION PROGRAM ..... 5
SCHEDULE OF COVERED SERVICES AND PROVISIONS ..... 7
GENE THERAPY FOR DUCHENNE MUSCULAR DYSTROPHY (DMD) ..... 18
TRANSPLANTS ..... 19
TRAVEL AND LODGING EXPENSES ..... 22
EXCLUSIONS ..... 23
DEFINITIONS ..... 27
ELIGIBILITY ..... 38
EMPLOYER POLICIES AND PROCEDURES ..... 40
INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS ..... 41
NETWORK BENEFITS ..... 43
OUT-OF-NETWORK BENEFITS ..... 44
PROCEDURES FOR FILING CLAIMS ..... 45
THIS PLAN AND MEDICARE ..... 47
GENERAL PROVISIONS ..... 48
COORDINATION OF BENEFITS (COB) ..... 62
COMPLIANCE REGULATIONS ..... 64
NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA ..... 66
ERISA RIGHTS SECTION ..... 72
STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “PRIVACY STANDARDS”) ..... 74
NOTICE OF PRIVACY PRACTICES ..... 77
STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “SECURITY STANDARDS”) ... 88

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# KEY INFORMATION

**EMPLOYER/COMPANY/PLAN ADMINISTRATOR/PLAN SPONSOR CONTACT INFORMATION:**
Forest River, Inc.
900 County Road 1 North
Elkhart, IN 46514
Phone: (574) 389-4600

**EMPLOYER/COMPANY IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):**
20-3284366

**PLAN NAME:**
Forest River, Inc. Employee Benefits Plan

**PLAN CONTACT INFORMATION:**
Human Resources Department
Forest River, Inc.
900 County Road 1 North
Elkhart, IN 46514
Phone: (574) 389-4600

**PLAN NUMBER:**
501

**STOP LOSS COVERAGE:**
The Company has purchased specific and aggregate stop-loss reinsurance coverage.

**GROUP NUMBER:**
A22100

**SPD EFFECTIVE DATE:**
January 1, 2026

**PLAN YEAR:**
The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends the last day of each December.

**TYPE OF PLAN:**
Medical and prescription drugs

**NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:**
Allied Benefit Systems, LLC
P. O. Box 211651
Eagan, MN 55121
Phone: (312) 906-8080 or (800) 288-2078 (outside IL)

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**PRIVACY OFFICERS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA):**

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

- Human Resources Manager.
- Staff designated by Human Resources Manager.
- Chief Financial Officer.
- Staff designated by Chief Financial Officer.

**ELIGIBILITY:**

- Employees: A person directly employed in the regular business of, and compensated for, services by the Company. This definition specifically excludes independent contractors and seasonal Employees.

- Retirees: This Plan does not cover retirees or their Dependents.

- Dependents Including:

    - Dependent Children: Child(ren) from birth to the last day of the month they attain age 26 consisting of natural children, stepchildren, foster children, adopted children, children placed for adoption, and children for whom You are the court-appointed legal guardian.

    - Spouse: This Plan defines "marriage" as both 1) a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage, and 2) a legal union between two persons of the same sex, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement.

    - Domestic Partners: **This Plan does not cover domestic partners**.

**WORKING SPOUSE COVERAGE PROVISION:**

No surcharge will be levied if the spouse of an eligible Employee is eligible for coverage through his employer and chooses coverage from this Plan.

**ENROLLMENT:**

- **Enrollment Waiting Period:**

  If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Employee or Dependent becomes eligible for coverage under the terms of this Plan.

- **Regular Full-time Employees:** You are eligible for coverage on the first day of the month coinciding with or following the date upon completion of 60 days of regular employment in a covered position.
- **Employees Under Special Contract:** You are eligible for coverage on the date as stated by the Employees contract.
- **Part-time to Full-Time:** Service is credited toward the Employee's waiting period from original hire date.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

- **Open Enrollment Period:**
  Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer.

- **Late Enrollment Period:**
  This Plan does not have a Late Enrollment period.

**TERMINATION OF COVERAGE:**

1. **Employee:** The coverage of any Employee covered under this Plan shall terminate on the earliest of the following**:**
   - The Saturday after the last day the Employee ceases to be eligible for coverage under the Plan, as listed in the Key Information section; or
   - The date of termination of the Plan.

2. **Dependent children (attaining age 26):** The coverage of Dependent children attaining age 26 covered under this Plan shall terminate on the earliest of the following:
   - The last day of the month such individual ceases to meet the definition of Dependent, as listed in the Key Information section; or
   - The date the Employee's coverage terminates under the Plan.

3. **Dependent (all others):** The coverage of any Dependent (other than identified above) covered under this Plan shall terminate on the earliest of the following:
   - The Saturday after the last day such individual ceases to meet the definition of Dependent, as listed in the Key Information section, however in the event of a divorce, coverage under this Plan shall terminate on the date the divorce is finalized, or
   - The date the Employee's coverage terminates under the Plan.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**IMPORTANT NETWORK CONTACT INFORMATION:**

| Function | Network Name | Claims Filing Information | Phone Number | URL |
|---|---|---|---|---|
| **PPO Network** | Anthem | Please file all claims with the Blue Cross and Blue Shield Plan in the state where services are rendered. | 800.676.BLUE | www.anthem.com |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# PRE-CERTIFICATION PROGRAM

Your Plan also includes a **pre-certification program**. The toll-free number You must use for pre-certification is shown on Your member ID card. **Failure to follow the guidelines listed below will subject Your benefits to a penalty for non-compliance as discussed in this section and referenced in the schedule of covered services and provisions.**

**The following services require pre-certification:**

1. Inpatient Hospital admissions.
2. Oncology Treatment.
    a. Chemotherapy (Including oral).
    b. Radiation Therapy.
    c. Oncology and transplant related injections, infusions and treatment (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine).

**If Your Physician recommends any service listed above, please follow these steps:**

1. Notify Your Physician that You participate in a pre-certification program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.

2. You or Your Physician must call the number shown on Your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission. Note: For exceptions, please refer to the section of this document entitled "Compliance Regulations," and see the subheading "Statement of Rights Under the Newborns' and Mothers' Health Protection Act".

3. If you are not able to call in advance, pre-certification is required following admission.

The following information will be needed to pre-certify:

| **Regarding Patient:** | **Regarding Employee:** |
|---|---|
| Name | Name |
| Address | Address |
| Telephone # | Telephone # |
| Date of Birth | Date of Birth |
| Relationship to Employee | Gender |
| Physician's Name | Social Security Number |
| Physician's Phone Number | Name of Employer |
| Hospital/Address | Name of Claims Processor:<br>*Allied Benefit Systems, LLC* |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

4. A nurse may call Your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.

5. When You or Your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:

   a. The facility can verify that pre-certification has been done and can track expected length of stay.

   b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

**Note**: Pre-certification assists in determining medical necessity and the best place for treatment. This service, however, does not guarantee payment, which is subject to eligibility and coverage at the time services are rendered.

**PENALTY FOR NON-COMPLIANCE:**

Unless prohibited under federal law, any non-compliance penalty specified in the Schedule of Covered Services and Provisions will apply under one or more of the following circumstances: a) a pre-certification call is not made according to the instructions within this section; b) an Inpatient stay exceeds the amount of days pre-certified; or c) a patient is admitted as an Inpatient when treatment could have been performed on an Outpatient basis.

This penalty will be applied in addition to any applicable Deductible and will not be applied to any Out-of-Pocket Maximum as specified in the "Schedule of Covered Services and Provisions". The penalty will be applied to Covered Services that were incurred during the days that were not pre-certified.

## PRE-NOTIFICATION

The following procedures are generally not covered by the Plan unless medically appropriate. Therefore, it is strongly recommended that a pre-notification of the following procedures be obtained before treatment. The toll-free number You should use for pre-notification is 800-892-1893.

Procedures for which pre-notification is recommended are:

1. Non-orthopedic imaging for CT, MRI, and PET Scans.
2. Neoplasm biopsies.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# SCHEDULE OF COVERED SERVICES AND PROVISIONS

## I. MEDICAL CARE BENEFITS:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Calendar Year Deductible** *(taken before benefits are payable unless waived)*<br>*This is an embedded Deductible, meaning each covered family member only needs to satisfy his or her individual Deductible, not the entire Family Deductible, prior to receiving plan benefits. The balance of the Family Deductible can be satisfied by one member or a combination of remaining family members.* | $5,000 per person<br>$10,000 per family | $10,000 per person<br>$20,000 per family |
| **Deductible Carry-Over** | Any Covered Services incurred during October, November and/or December which are applied to the Covered Person's Deductible will also "carry-over" to the following year's Deductible. | |
| **Out-of-Pocket Maximum per Calendar Year** *(*medical co-pays, Co-Insurance and Deductibles count towards the Out-of-Pocket Maximum)<br>*After amount is reached, 100% level of benefits applies for that Calendar Year.* The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum:<br>• Rx co-pays (see separate Prescription Drug Out-of-Pocket listed below)<br>• "Non-compliance penalty" (for failure to abide by pre-certification requirements).<br>• Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit.<br>*This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits paid at 100%. The balance of the family Out-of-Pocket Maximum can be satisfied by one member or a combination of remaining family members.* | $6,500 per person<br>$13,000 per family | $13,000 per person<br>$26,000 per family |
| **Prescription Drug Out-of-Pocket Maximum per Calendar Year**<br>*After amount is reached, the Plan will pay 100% for prescription drugs for the remainder of the Calendar Year.* | $2,500 per person<br>$5,000 per family | |
| **Calendar Year Benefit Maximum** | Unlimited | |
| **Precertification Penalty for Non-Compliance: Certain benefits are subject to a $250 penalty** per occurrence ***(in addition to Deductible)*** for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section for additional information. | Allied Care<br>1-800-892-1893 | |
| **Claims Filing Limit** | All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred. | |
| **Coordination of Benefits** | If it is determined that this Plan is the secondary payer, benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges. | |
| **In-network and out-of-network Deductibles and Out-of-Pocket Maximums are "aggregated," such that Covered Services applied to one also apply to the other.** | | |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## II. PRESCRIPTION DRUG BENEFIT:

| COVERED SERVICES and PROVISIONS | In-Network / Out-of-Network |
|---|---|
| *Your Prescription Drug Benefit is administered by Capital Rx. For prescription drug questions please call 1-833-599-0979 or visit www.cap-rx.com.* | |
| *If member requests brand only when a generic is available, the member will be charged the generic co-pay plus the cost difference between the brand and generic medication. The amount of this cost difference does not apply to the Deductibles or Out-of-Pocket Maximums.* | |
| **Separate Prescription Drug Deductible per Calendar Year** | $250 per person<br>$500 per family |
| **Prescription Drug Out-of-Pocket Maximum per Calendar Year**<br><br>*After amount is reached, the Plan will pay 100% for prescription drugs for the remainder of the Calendar Year.* | $2,500 per person<br>$5,000 per family |
| **Prescription Drug Card Benefit** *(up to 30-day supply per prescription through participating pharmacies)* | 10% up to a maximum co-pay of $40/generic,<br>20% up to a maximum co-pay of $100/brand,<br>30% up to a maximum co-pay of $300/Non-preferred brand<br>(per prescription).<br>After Deductible |
| **Extended Retail Pharmacy Drug Benefit** *(up to 90-day supply per prescription through any participating pharmacy) except where prohibited by state or federal law.* | $40/generic, $100/brand, $300/Non-preferred brand (per prescription).<br>After Deductible |
| **Mail-Order Drug Benefit** *(up to 90-day supply per prescription through mail order) except where prohibited by state or federal law.* | $40/generic, $100/brand, $300/Non-preferred brand (per prescription).<br>After Deductible |
| **Mail-Order/Extended Retail Pharmacy Requirement** | Optional |
| **Specialty Drug Benefit** *(up to 30-day supply per prescription, includes certain injectable medications) except where prohibited by state or federal law.* | 40% up to a maximum co-pay of $400,<br>After Deductible |
| *Note: Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations* | |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## III. PREVENTIVE CARE SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Preventive Care Services** - (*must be billed with a routine diagnosis).*<br><br>This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years).<br><br>*This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.*<br><br>This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests, *see Outpatient services for more details.* | 100%<br>Deductible waived. | Not Covered |
| **Routine visits related to Obesity management** | 100%<br>Deductible waived. | Not Covered |
| **Preventive Care Services – Mammograms** *(regardless of diagnosis)*<br><br>• Mammograms (including 3D), once every year (age 40 or older)<br><br>*Note: The first mammogram in a Calendar Year shall be paid according to this benefit regardless of diagnosis, all other diagnostic mammograms within the same Calendar Year shall be paid at standard co-insurance.* | 100%<br>Deductible waived. | Not Covered |
| **Preventive Care Services – Colonoscopy/Sigmoidoscopy**- (*must be billed with a routine diagnosis).*<br><br>• Choice between a sigmoidoscopy or a colonoscopy once every 5 years (age 45 or older) | 100%<br>Deductible waived. | Not Covered |
| **Family history benefit**<br><br>*Any age or visit limit maximums will not apply when family history is the only diagnosis billed for routine tests. This benefit is limited to the services referenced within the Recommendations of the United States Preventive Service Task Force, as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine*. | 100%<br>Deductible waived. | Not Covered |
| **Family Planning - Permanent Procedures for Women**<br><br>*Includes:*<br>• *Sterilization.* | 100%<br>Deductible waived. | Not Covered |
| **Family Planning – Temporary Procedures**<br><br>*Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.* | 100%<br>Deductible waived. | Not Covered |
| **Breast Pumps and Supplies (Includes one breast pump per pregnancy and certain covered supplies purchased through a retail supplier).** | 100%<br>Deductible waived. | 100%<br>Deductible waived. |
| **Immunizations (including flu shots) provided at retail clinics** *such as, but not limited to, Walgreens, CVS, Walmart, Jewel-Osco, etc.* | 100%<br>Deductible waived. | 100%<br>Deductible waived. |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## IV. PHYSICIAN SERVICES:

| COVERED SERVICES and PROVISIONS<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| TELADOC™<br>Teladoc provides access to a national network of U.S. board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone, by calling 1-800-Teladoc (835-2362), or online video consultations by accessing www.teladoc.com. Teladoc does not replace the existing primary care physician relationship, but enhances it as a convenient, affordable alternative for medical care. | 100%<br>Deductible Waived | |
| **Virtual Physician charges** | Paid same as any other service according to type of service and provider. | |
| **Minor Medical Services** *to the extent available and provided* **at Retail Clinics** *such as, but not limited to, Walgreen's, CVS, Walmart, Osco, etc.* ***This does not include the cost of any take home medications or items provided, or the charge for any other provider in association with the visit.*** *Any such charges will be covered as shown elsewhere in this schedule.* | $30 co-pay, then paid at 100%<br>Deductible waived<br>(Co-pay applies to the in-network Out-of-Pocket Maximum) | |
| **Physician Office Visits –** *includes all services done during the office visit.*<br>*Allied considers the following doctors as primary care physicians, all others would be specialists:*<br>• *General Practice.*<br>• *Family Practice.*<br>• *OB/Gyn.*<br>• *Internal Medicine.*<br>• *Osteopaths.*<br>• *Pediatricians.*<br>• *Nurse Practitioners.*<br>• *Physician Assistants.*<br>• *All covered Mental Health providers* | $40 co-pay, then paid at 100%<br>Deductible waived | 60% |
| **Urgent Care** - *includes facility fees and all other services done during the urgent care visit.* | $50 co-pay, then paid at 100%<br>Deductible waived | 60% |
| **Specialist Office Visits –** *includes all services done during the office visit.* | $60 co-pay, then paid at 100%<br>Deductible waived | 60% |
| **Second Surgical Opinion** | 100%<br>Deductible waived | 100%<br>Deductible waived |
| **Emergency Room Physician Care** | Please refer to Emergency Room Services benefit in Section VI. | |
| **Physical/Occupational/Speech Therapy - Office Services** | $50 co-pay per visit, then paid at 100%<br>Deductible waived | 60% |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## IV. PHYSICIAN SERVICES:

| COVERED SERVICES and PROVISIONS<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Physical/Occupational/Speech Therapy - Outpatient Services** | 80% | 60% |
| **All Care Rendered by a Chiropractor** | $50 co-pay per visit, then paid at 100%<br>Deductible waived | 60% |
| **Anesthesia and its Administration** *(Inpatient/Outpatient)* | 80% | 60% |
| **Other Physician Services**<br>*Does not include Outpatient/Independent Laboratory labs and X-rays; please see Section V for additional benefit coverage information.* | 80% | 60% |
| **If a referral is made to a non-network Physician or non-network specialist/facility by a network Physician** (due to Medically Necessary services not being available In-Network). | N/A | Paid same as In Network. |
| **Non-Network Physician Services Received at a Network Hospital**<br>If services are performed by a non-network Physician/specialist, who is requested or required by that network Hospital, the charges will be covered as if rendered by a network Physician/specialist. | N/A | Paid same as In-Network. |

## V. OUTPATIENT/INDEPENDENT LABORATORY RADIOLOGY/PATHOLOGY SERVICES, INCLUDING ADMINISTRATION AND MRI, PET, AND CT SCANS:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Independent Laboratory Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services**<br>*Does not include above services performed in conjunction with the following:*<br>• *Emergency Room Services.*<br>• *Urgent Care Services.*<br>*Does not include MRI, PET or CT scans.* | 90% | 60% |
| **Outpatient Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services**<br>*Does not include above services performed in conjunction with the following:*<br>• *Emergency Room Services.*<br>• *Urgent Care Services.*<br>*Does not include MRI, PET or CT scans.* | 80% | 60% |
| **Outpatient Imaging Services (MRI, PET, and CT scans)** | 80% | 60% |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## VI. FACILITY SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **Emergency Room Services**<br>*Note: See the "Out-of-Network Benefits" section for more information regarding out of network Emergency Room Services.* | 80% | Paid Same as in-network |
| **Inpatient Hospital Services**<br>*Coverage is limited to:*<br>• *Room and board not to exceed the semi-private room rate.*<br>• *Necessary services and supplies including an intensive care unit and a cardiac care unit.*<br>• *If admitted through the Hospital emergency room, this benefit will be covered at the in-network level. Notice and consent rules may apply to certain post-stabilization items and services. See Emergency Room Services in the "Definitions" section.*<br>*Note: Room and board subject to the payment of semi-private room rate, unless the Hospital only has private rooms.* | 80% | 60% |
| **Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures** | 90% | 60% |
| **Outpatient Hospital Facility Charges** | 80% | 60% |
| **Renal Dialysis** | 80% | 60% |
| **Urgent Care Services – facility fees** | Please refer to Urgent Care Services benefit in Section IV. | |

## VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

| COVERED SERVICES and PROVISIONS | In-Network | Out-of-Network |
|---|---|---|
| **BEHAVIOR HEALTH BENEFIT (Mental/Nervous/Substance Use Disorders)** | | |
| **Treatment for Mental/Nervous and Substance Use Disorders**<br>*Please see the definitions of Physician and Hospital for further detail.* | Paid same as any other service according to type of service, provider and place of service. | |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## VIII. TRANSPLANT SERVICES:

| COVERED SERVICES and PROVISIONS<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Organ or Tissue Transplant Procedures at a Blue Distinction Center facility or Anthem Center of Medical Excellence)** | 100%<br>Deductible waived | |
| **Organ or Tissue Transplant Procedures (other than provided at a Blue Distinction Center facility or Anthem Center of Medical Excellence)**<br>**For cornea, skin, or cartilage transplants:**<br>*The Covered Person, who is the transplant recipient, must receive 2 opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.* | Coverage and Benefit Level based upon place and type of service. | Coverage and Benefit Level based upon place and type of service. |
| **For all other Organ and Tissue Transplants:**<br>*For specific details on all elements of this coverage, please refer to the Transplants section.* | Coverage and Benefit Level based upon place and type of service. | Not Covered |

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Abortion-** *only if mother's life is endangered if pregnancy is carried to term, or if medically indicated due to complication with pregnancy.* | 80% | 60% |
| **Acupuncture** | Not Covered | |
| **Assisted Reproduction** | Not Covered | |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br><br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br><br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Autism Spectrum Disorders**<br>*For those diagnosed with this disorder, the following treatments are covered:*<br>• *Psychiatric and Psychological care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist or psychologist;*<br>• *Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.*<br>*Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.* | 80%<br>Except as may be covered differently for specific services listed elsewhere in the schedule. | 60%<br>Except as may be covered differently for specific services listed elsewhere in the schedule. |
| **Casts, Splints, Trusses, and Braces** | 80% | 60% |
| **Contact Lenses or Glasses Following Cataract Surgery**<br>*Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.* | 80% | 60% |
| **Dental Treatment** *when rendered by a Physician, dentist, or oral surgeon for* ***a*** **fractured jaw** *or for* **accidental Injuries to natural teeth within 6 months** *after the accident (replacement or repair of a denture not covered)*; *removal of* **total bony impacted teeth**; *charges for* **medical care, services** *and* **supplies** *furnished by a Hospital during Medically Necessary confinement in connection with* dental treatment. | 80% | 60% |
| **Durable Medical Equipment**<br>*Includes:*<br>• *Cost to purchase or rent up to purchase price.*<br>• *Insulin pump, glucose monitors and other diabetic supplies when Medically Necessary and not covered though Your prescription drug vendor.*<br>• *Equipment for administration of oxygen.*<br>• *Equipment repair or replacement.* | 80% | 60% |
| **Family Planning - Permanent Procedures for Men**<br>*Includes:*<br>• *Sterilization.*<br>  ○ *Male vasectomy.* | 80% | 60% |
| **Foot Orthotics** | Not covered | |
| **Gender Affirming Surgery (including any associated labs and x-rays)** | 80% | 60% |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br><br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br><br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Hearing exams**<br>*Hearing screenings from birth through age 21 are covered under the Preventive Care benefit.* | 80% | 60% |
| **Home Health Care**<br>*Limited to a maximum of 60 home care visits per Covered Person per Calendar Year.*<br>*Each 4 hours of service by a home health aide in a 24-hour period will be considered 1 home health visit.*<br>*One visit by any other provider of services will be counted as 1 visit.* | 80% | 60% |
| **Hospice Care**<br>*Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.* | 80% | 60% |
| **Infertility Testing**<br>*Limited to Covered Services necessary to diagnose this condition only.*<br>*This benefit does not cover charges in connection with the promotion of conception (see Assisted Reproduction benefit for details). Infertility means the inability to conceive a child, or the inability to sustain a successful pregnancy* | Paid same as any other service according to type of service, provider and place of service. | |
| **Infusion therapy and Injections when administered in a Physician's office or facility**<br>*The first dose of infusion therapy may be given at the Physician's facility of choice, including Outpatient Hospitals, free-standing facilities and home care. Any subsequent dose may also be given at the Physician's facility of choice, but only when clinically appropriate and at a lower cost than other sites of administration.*<br>*Note: Self-administered injections, topical solutions, and oral specialty medications are not covered under this Plan. Delandistrogene moxeparvovec-rokl (ELEVIDYS) requires medical necessity as defined on pages 9/10. If Plan requirements are not met, the therapy is excluded.* | 80% | 60% |
| **Mastectomy Related Treatment**<br>*Includes charges in accordance with the provisions detailed under the definition of "Reconstructive Breast Surgery."* | 80% | 60% |
| **Non-Surgical Obesity Treatment** | 80% | 60% |
| **Nutritional Counseling, regardless of underlying covered condition** | 80% | 60% |
| **Obesity Surgery** | Not Covered | |
| **Orthopedic Shoes**<br>*Limited to specially molded and Medically Necessary shoes.*<br>*Limited to 1 pair per Covered Person every 24 months.* | 80% | 60% |
| **Private Duty Nursing Services** | Not Covered | |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br><br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br><br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Professional Ambulance Service**<br>*Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.*<br>*Note: See the "Out-of-Network Benefits" section for more information regarding out of network Air Ambulance services.* | 80% | 80%<br>(Subject to the in-network deductible and Out-of-Pocket maximum) |
| **Prosthetic Medical Appliances (including Artificial Limbs, Eyes and Larynx)**<br>*Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.* | 80% | 60% |
| **Routine Newborn Nursery Care** *(including circumcision)* | 80% | 60% |
| **Self-administered injections, topical solution, and oral specialty prescription medication** | Not Covered | |
| ***Services/Items for Covered Persons Residing Outside the PPO Network Area*** | *N/A* | *Paid same as any other in-network service according to type of service, provider and place of service.* |
| **Skilled Nursing Facility**<br>*Includes Extended Care Facility.*<br>*Limited to 60 days per Covered Person per Calendar Year.*<br>*Limited to the usual charge of the facility for semi-private care, including room and board and all other services.* | 80% | 60% |
| **Sleep Studies (*home)*** | 80% | 60% |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

## IX. OTHER COVERED SERVICES:

| COVERED SERVICES and PROVISIONS<br><br>**Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.**<br><br>*Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.* | In-Network | Out-of-Network |
|---|---|---|
| **Sleep Studies *(In-lab, facility) ages 18 and over***<br>In order to be eligible, the member must have **one of the following**:<br>• Excessive daytime sleepiness<br>• Epworth Sleepiness Scale (ESS) score of 10 or greater<br>• Witnessed apneas, choking, or gasping<br>**AND one of the following** comorbid conditions:<br>• moderate to severe pulmonary disease<br>• neuromuscular disease<br>• stroke<br>• epilepsy<br>• congestive heart failure (NYHA class III or IV)<br>• pulmonary hypertension<br>• chronic opioid medication use<br>• super obesity (BMI > 45)<br>• periodic limb movement disorder<br>• parasomnias<br>• severe insomnia<br>• narcolepsy<br>• central sleep apnea or complex sleep apnea<br>• negative or technically inadequate home sleep study results<br>• Inability to use portable monitoring equipment safely at home. | 80% | 60% |
| **Sleep Studies *(In-lab, facility) ages 17 and under***<br>In order to be eligible, the member must be under 18 years of age and have one of the following indications:<br>• Snoring<br>• Hypersomnia<br>• Suspected obstructive sleep apnea<br>• Suspected narcolepsy<br>• Suspected parasomnia<br>• Suspected restless leg syndrome<br>• Suspected periodic limb movement disorder<br>• Suspected congenital central alveolar hypoventilation syndrome<br>• Suspected sleep-related hypoventilation due to neuromuscular disorders or chest wall deformities<br>• After adenotonsillectomy or pharyngeal surgery for OSA | 80% | 60% |
| **TMJ** *(Temporomandibular Joint Dysfunction)*<br>*Limited to $1,000 Maximum paid per Covered Person per Lifetime.*<br>*Benefit does not include charges for orthodontic services.* | 80% | 60% |
| **Wigs** *for hair loss resulting from the treatment of cancer.* | 80% | 60% |
| **Please Refer to the Pre-Certification Program, Transplants, and Exclusions sections for additional coverage details.** | | |

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# GENE THERAPY FOR DUCHENNE MUSCULAR DYSTROPHY (DMD)

Gene therapy for Duchenne muscular dystrophy (DMD), a rare and serious genetic disease affecting muscle strength and movement. Gene therapy is being proposed as a one-time treatment to significantly lessen the severity of DMD. At this time, one gene therapy has been approved by the Food and Drug Administration (FDA) to treat DMD: delandistrogene moxeparvovec-rokl (ELEVIDYS), an adeno-associated virus vector-based gene therapy.

**Note:** Please refer to the applicable clinical pharmacy criteria used by the Plan for information regarding disease-modifying treatments for DMD; for example: casimersen (Amondys 45), viltolarsen (Viltepso), and golodirsen (Vyondys 53).

**Medically Necessary:**
A one-time infusion of delandistrogene moxeparvovec-rokl (ELEVIDYS) is considered **Medically Necessary** in individuals who meet **all** of the following criteria:

A. Diagnosis of Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene; **and**
B. No deletion in exon 8 or exon 9 in DMD gene; **and**
C. Ambulatory; **and**
D. Age 4 through 5 years (at least 4 years 0 days and less than 6 years old); **and**
E. Anti-AAVrh74 total binding antibody titers less than 1:400; **and**
F. Absence of active infection; **and**
G. Absence of significant liver dysfunction or disease, defined as *at least one of the following*:
    1. Preexisting liver impairment; **or**
    2. Chronic hepatic condition; **or**
    3. Acute liver disease (e.g., acute hepatic viral infection).

**Investigational and Not Medically Necessary:**
Delandistrogene moxeparvovec-rokl (ELEVIDYS) is considered **investigational and not Medically Necessary** when the criteria above are not met.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# TRANSPLANTS

**PREFERRED TRANSPLANT NETWORK FACILITY:**

A Preferred Transplant Network Facility is a facility contracted with the Plan's Preferred Transplant Network (PTN) to furnish particular services and supplies to You or Your Dependent in connection with one or more highly specialized medical procedures. The maximum charge made by the PTN for such services and supplies will be the amount agreed to between the Plan's PTN and the PTN facility.

**TRANSPLANT EXPENSES**

Once it has been determined that You or one of Your Dependents may require an ***organ*** transplant, You or Your Physician should follow the guidelines listed in the Pre-Certification Program to coordinate Your transplant care. You must follow any pre-certification requirements. ***Organ*** means solid organ, stem cell, bone marrow, or tissue.

While all organ transplants (other than cornea or skin transplants) are covered only under this section, benefits may vary if a PTN facility or non-PTN facility is used. The PTN facility must be specifically approved and designated by the PTN to perform the procedure You require. A transplant will be covered as in-network only if performed in a facility that has been designated as a PTN facility for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as a PTN facility, even if the facility is considered as a network facility for other types of services, will not be considered in-network.

## COVERED TRANSPLANT EXPENSES

Covered transplant expenses include the following (unless stipulated otherwise by a separate transplant agreement between the Plan, PTN, and PTN facility):

- Inpatient and Outpatient expenses directly related to a transplant**.**
- Charges made by a Physician or transplant team.
- Charges made by a Hospital**,** outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the PTN facility during the transplant process. These services and supplies may include: physical therapy, speech therapy and occupational therapy; bio-medicals and immunosuppressants; and home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date You are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes Inpatient and Outpatient services for all covered transplant-related health services and supplies provided to You and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during Your Inpatient stay or Outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during Your Inpatient stay or Outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following organ transplants will be considered one transplant occurrence:

- Heart transplant.
- Lung transplant.
- Heart/lung transplant.
- Simultaneous Pancreas Kidney (SPK) transplant.
- Pancreas transplant.
- Kidney transplant.
- Liver transplant.
- Intestine transplant.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant surgery.
- Sequential transplants.
- Re-transplant of same organ type within 180 days of the first transplant.
- Any other single organ transplant, unless otherwise excluded under the Plan.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

The following will be considered to be more than one transplant occurrence:

- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

***Limitations***

The transplant coverage does not include charges for:

- Outpatient drugs, including bio-medicals and immunosuppressants, not expressly related to an Outpatient transplant occurrence.
- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the transplant occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.
- For donor services if You or Your covered Dependent are a donor.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# TRAVEL AND LODGING EXPENSES

**Travel and lodging expenses** are covered under the Plan when necessary to obtain any type of care covered by the Plan when the care is not available from any provider or facility within 100 miles from the patient's principal residence. Coverage of travel and lodging expenses will be limited to the closest provider or facility capable of providing the service(s) at issue, and coverage of travel and lodging expenses will only be provided in connection with obtaining services that are lawfully provided in the jurisdiction where they are performed.

Travel shall be reimbursed between the patient's home and the provider or facility for round trip (air, train or bus) transportation costs, including local transportation (such as taxi, rideshare, or public transit) when required. Only transportation costs that are reasonable in amount (for example, coach class only) will be covered. If traveling by auto to the facility, reasonable mileage, parking and toll costs are reimbursed. Reasonable mileage reimbursement shall be limited to the tax-free cap authorized by the Federal government for medical travel, as adjusted (up or down) for inflation.

Reimbursement of expenses incurred by the patient for lodging is limited to a maximum rate of $50 per night, payable at 100% Deductible waived. If a traveling companion is necessary to enable the patient to receive medical care, the companion's reasonable travel and lodging expenses will also be covered, with lodging expenses also reimbursed at a maximum rate of $50 per night, payable at 100% Deductible waived. Travel & lodging reimbursement is limited to a total cap of $10,000 per Calendar Year, payable at 100% Deductible waived, which is the combined maximum for both the patient and companion and applies collectively to all trips taken in a Calendar Year.

Third-party documentation, such as receipts, must be provided to substantiate any claimed reimbursement of travel and lodging expenses.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions (unless specifically stated within the Schedule of Covered Services and Provisions):

1. for or in connection with an Injury or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation, Occupational Disease, or similar law;
2. for care and treatment of an Injury or Illness arising out of, or in the course of, any employment for wage or profit;
3. in a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;
4. for charges which the Covered Person is not legally required to pay or for charges which would not have been made if no coverage had existed;
5. which are not Reasonable and/or in excess of Usual and Customary Charges (depending on contract provisions, this limitation may not apply to charges from network providers or non-network providers who are utilized as a result of requests or requirements of network providers), unless otherwise set forth in the "Out-of-Network Benefits" section;
6. which are for care or treatment which is not Medically Necessary;
7. for custodial care (Expenses incurred to assist a person in daily living activities are considered costs for custodial care. Costs for medical maintenance services and supplies in connection with custodial care due to age, mental or physical conditions, are not covered if such care cannot reasonably be expected to improve a medical condition.);
8. due to accidental bodily Injury or Illness resulting from participation in an insurrection or riot, or participation in the commission of an assault or felony;
9. for purchase or rental of personal comfort items or supplies of common use; for purchase or rental of blood pressure kits, exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steam rooms and/or swimming pools;
10. for non-medical expenses such as preparing medical reports, itemized bills or charges for mailing;
11. for training, educational instructions or materials, even if they are performed or prescribed by a Physician (except as stated in the Schedule of Covered Services);
12. for legal fees and expenses incurred in obtaining medical treatment;
13. for genetic testing and counseling (except as may be specifically stated as covered elsewhere in this document);

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

14. for Friday and Saturday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24-hour period immediately following admission;
15. for treatment by a Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N) if the Physician or nurse is related by blood, marriage, or by legal adoption to either the Covered Person or a spouse, or ordinarily resides with the Covered Person;
16. for any expense in excess of any maximum or limit as stated elsewhere in this document;
17. for failure to provide any additional documentation or information as may be requested pursuant to the "Procedures For Filing Claims" section of this Plan;
18. for charges for travel or accommodations, whether or not recommended by a Physician, unless specifically stated as covered;
19. for charges incurred before coverage was effective or after it was terminated;
20. for charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material;
21. except as stated in the Schedule of Covered Services and Provisions, 1) for treatment of or to the teeth, the nerves or roots of the teeth, and 2) for the repair or replacement of a denture;
22. for research studies not reasonably necessary to the treatment of an Illness or Injury;
23. This Exclusion is intentionally left blank;
24. This Exclusion is intentionally left blank;
25. for treatment for sexual dysfunction or inadequacy (except as may be covered under the prescription drug benefit), including implants and related hormone treatment;
26. for vitamins (except prescription pre-natal and pediatric vitamins); for over-the-counter drugs regardless of being prescribed by a Physician, unless required by federal law;
27. for routine foot care such as removal of corns, calluses or toenails, except in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy;
28. for splints or braces for non-medical purposes (i.e. supports worn primarily during participation in sports or similar physical activities);
29. for any form of medication or treatment not prescribed in relation to an Injury, Illness or pregnancy, unless stated as covered elsewhere in this document;
30. for growth hormones for children with short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
31. on account of any declared or undeclared act of war;

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

32. for charges in connection with Cosmetic Surgery/Treatment, except to correct deformities resulting from Injuries sustained in an accident; or due to an Illness such as breast cancer (including all services mandated by federal provisions related to mastectomy treatment – see definition of "Reconstructive Breast Surgery Coverage"); or to correct a functional disorder (functional disorders do not include mental or emotional distress related to a physical condition); or unless treatment is for correction of a functional abnormal congenital condition;
33. This Exclusion is intentionally left blank;
34. for expenses incurred for cryo-preservation and storage of sperm, eggs and embryos;
35. for charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies;
36. for special education services (unless specifically referenced in the Schedule of Covered Services);
37. for experimental or investigational services; or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States;
38. for routine eye examinations, unless required by federal law; for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses; for any procedure, treatment or exam in connection with refractive disorders; for eye surgery such as radial keratotomy;
39. This Exclusion is intentionally left blank;
40. for hearing aids, or the fitting thereof;
41. for instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician (except as referenced in the Schedule of Covered Services);
42. for surgery or treatment for obesity (except as referenced in the Schedule of Covered Services);
43. for surgical reversal of elective sterilizations; for elective abortions;
44. for chelation (metallic ion) therapy, except as approved by the Food and Drug Administration;
45. for "nicotine patches" or other forms of anti-smoking medication (except as covered under the prescription drug benefit);
46. for care and treatment for hair loss including wigs, hair transplants, hair implants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy;

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

47. for any service for assisted reproduction (including in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer); however, diagnosis and treatment of medical conditions (such as endometriosis) that may contribute to the condition of infertility are covered;
48. for services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;
49. This Exclusion is intentionally left blank;
50. for marital counseling services;
51. This Exclusion is intentionally left blank;
52. for expenses for injuries incurred in the commission of a criminal act involving the use of alcohol or illegal drugs;
53. This Exclusion is intentionally left blank;
54. This Exclusion is intentionally left blank;
55. for out-of-network facility charges (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits" section), payment will be limited to 175% of the Medicare DRG Reimbursement Rate or the Medicare APC Reimbursement Rate (whichever is appropriate);
56. for out-of-network professional charges billed on a Form CMS-1500, payment will be limited to 135% of the Medicare fee schedule (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits" section);
57. This Exclusion is intentionally left blank;
58. This Exclusion is intentionally left blank;
59. This Exclusion is intentionally left blank;
60. This Exclusion is intentionally left blank;
61. This Exclusion is intentionally left blank;
62. This Exclusion is intentionally left blank;
63. This Exclusion is intentionally left blank;
64. for provider charges claimed as a result of purported lost discounts;
65. for charges for oral nutrition including infant formula.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# DEFINITIONS

***Certain words and terms used herein shall be defined as follows:***

**AIR AMBULANCE**

Medical transport by a rotary wing air ambulance or fixed wing air ambulance that is otherwise covered by the Plan.

**AMBULATORY SURGICAL CENTER**

Any private or public establishment with: a) an organized medical staff of Physicians; b) permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient surgical procedures; c) continuous Physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

**ANCILLARY SERVICES**

Items and services provided by an out-of-network provider at an in-network facility that are related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at the in-network facility.

**CALENDAR YEAR**

That period of time commencing at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new Calendar Year.

**CASE MANAGEMENT PROGRAM**

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of in-Hospital treatment.

If, at any point in the progress of a given medical situation, after having considered the opinions of the Covered Person (and/or his legally responsible representatives), the Covered Person's Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**CLAIMS PROCESSOR**

The entity providing consulting services to the Company in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Processor is Allied Benefit Systems, LLC, P. O. Box 211651, Eagan, MN 55121.

**COMPANY**

See the Key Information section at the beginning of this document.

**COSMETIC SURGERY/TREATMENT**

Surgery or treatment that is intended to improve the appearance of a patient or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease (except when necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an accident or trauma, or a disfiguring disease).

**COVERED PERSON / PLAN PARTICIPANT**

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Company employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

**COVERED SERVICES**

These are expenses for certain Hospital and other medical services and supplies for the treatment of Injury or Illness. A detailed list of Covered Services is set forth in this booklet in the section entitled "Schedule of Covered Services and Provisions."

**DEDUCTIBLE/CO-INSURANCE**

The amount of eligible expense incurred in any Calendar Year, which must be satisfied by the Covered Person before benefits are paid. Upon receipt of satisfactory proof that a Covered Person has incurred Covered Services as a result of an Injury or Illness, the Plan, after deducting the Deductible amount shown in the Schedule of Covered Services and Provisions from the Covered Services first incurred during that Calendar Year, will pay benefits at the appropriate Co-Insurance level as shown in the Schedule of Covered Services and Provisions.

**DEPENDENTS**

Spouse of the Employee who is a resident of the same country in which the Employee resides. For additional information, see the Key Information section at the beginning of this document.

Children from birth to the last day of the month they attain age 26. The term *"child"* or *"children"* include children that are specified within the Key Information section at the beginning of this document.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

**DOMESTIC PARTNER**

See the Key Information section at the beginning of this document.

**ELECTIVE SURGICAL PROCEDURE**

Any non-emergency surgical procedure which may be scheduled at a patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions and which is performed while the patient is confined in a Hospital as an Inpatient or in an Ambulatory Surgical Center.

**EMERGENCY ROOM SERVICES**

**"**Emergency Room Services**"** are services provided with respect to a Medical Emergency in an emergency department of a Hospital or an independent freestanding emergency department, to evaluate, stabilize, and treat the patient. Covered Services provided by an out of network provider or facility after a patient has stabilized and as part of Outpatient observation or a required Inpatient or Outpatient stay immediately following and related to the illness or injury for which the Emergency Room Services were needed will also be considered Emergency Room Services unless the following conditions are satisfied:

- The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition. The attending emergency physician's or treating provider's determination is binding on the facility for purposes of this requirement.
- The provider or facility furnishing such additional items and services satisfies the notice and consent criteria prescribed by federal law with respect to such items and services;
- The patient is able to receive the notice and provide consent, as determined by the attending emergency Physician or treating provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable state law.
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed under state law.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

A nonparticipating provider or nonparticipating facility described above will always be considered providing Emergency Room Services with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or nonparticipating emergency facility satisfied the notice and consent requirement described above.

Coverage for Emergency Room Services will be provided consistent with the No Surprises Act and the terms of this Plan.

**EMPLOYEE**

See the Key Information section at the beginning of this document.

**EMPLOYER**

See the Key Information section at the beginning of this document.

**ENROLLMENT DATE**

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

**ESSENTIAL HEALTH BENEFITS**

"Essential Health Benefits" include 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 use 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.

**EXTENDED CARE FACILITY**

An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the elderly, a place for rest, or a place for custodial or educational care.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**FAMILY DEDUCTIBLE**

If the amount of Covered Services incurred by family members and applied toward the Deductible totals the amount shown in the Schedule of Covered Services and Provisions, the Deductible amount shall be waived for all other members of that family unit for that Calendar Year.

**GENDER NEUTRAL WORDING**

A masculine pronoun in this document shall at all times be considered synonymous with a feminine pronoun unless the context indicates otherwise.

**GENETIC INFORMATION**

The term "genetic information" is defined as 1) an individual's own genetic tests, 2) the genetic tests of family members of such individual, and 3) the manifestation of a disease or disorder in family members of such individual. The term “genetic information” also encompasses family medical history. The term "genetic information" additionally extends to genetic information of any fetus carried by a pregnant woman. With respect to an individual or family member utilizing an assisted reproductive technology, genetic information includes the genetic information of any embryo legally held by the individual or family member. The term “genetic information” further extends to dependents and family members defined as first-degree, second-degree, third-degree, or fourth-degree relatives of the individual. The term additionally includes participation in clinical research involving genetic services.

**HOME HEALTH CARE AGENCY**

A public or private agency that is primarily engaged in providing skilled nursing and other therapeutic services and is either (1) licensed or certified as a home health agency by the governing jurisdiction; or (2) certified as a home health agency by Medicare.

**HOSPICE**

A facility established to furnish terminally ill patients a coordinated program of Inpatient and home care of a palliative and supportive nature. A hospice must be approved as meeting established standards, including any legal licensing requirements.

**HOSPITAL**

An institution which meets all of the following requirements; (a) maintains permanent and full-time facilities for bed care of resident patients; (b) has a doctor in regular attendance; (c) continuously provides 24 hour a day nursing services by Registered Nurses (R.N.); (d) is primarily engaged in providing diagnostic and therapeutic services and facilities for medical and surgical care of Injuries or Illnesses on a basis other than a rest home, nursing home, convalescent home, or a home for the aged; (e) maintains facilities on the premises for surgery; (f) is operating lawfully as a Hospital in the jurisdiction where it is located; and (g) is either accredited by the Joint Commission on the Accreditation of Healthcare Organizations or is Medicare approved.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

In addition, the term "Hospital" shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

**HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT**

Only a section, ward or wing within the Hospital which is distinguishable from other Hospital facilities because it (a) is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients, including constant observation and care by a Registered Nurse (R.N.) or other highly trained Hospital personnel, and (b) has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

**HOSPITAL SEMI-PRIVATE**

The room and board charge is not to exceed the semi-private room rate. The difference between the semi-private room rate and the private room rate will be the patient's responsibility and will not apply to, or be affected by, any Out-of-Pocket Maximum provision. However, if 1) a private room is required due to Medical Necessity, or 2) the Hospital only has private rooms, the full private room charge will be considered.

**ILLNESS**

Only non-occupational sickness, disease, mental infirmity, or pregnancy (including surrogacy), all of which require treatment by a Physician.

**INJURY**

Only non-occupational bodily Injury which requires treatment by a Physician.

**INPATIENT**

A Covered Person shall be considered to be an "Inpatient" if he is treated at a Hospital and is confined for 23 or more consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by the patient's Physician as an alternative to Hospital confinement.

**LATE ENROLLMENT**

An enrollment which takes place other than during the first period during which an individual was eligible for coverage, or other than during a period of Special Enrollment or Open Enrollment. See the Key Information section at the beginning of this document for applicability.

**LIFETIME**

Shall mean, "while covered under the Plan". Under no circumstances will the word "Lifetime" mean "during the lifetime of the Covered Person".

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**MEDICAL EMERGENCY**

A **"**Medical Emergency**"** is defined as a medical condition, including a Mental/Nervous or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

**MEDICALLY NECESSARY**

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

**MEDICARE DRG OR APC REIMBURSEMENT RATE**

The inpatient and outpatient reimbursement rates set by Centers for Medicare and Medicaid Services (CMS).

**MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES**

Services for diagnoses that are listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered.

**NAMED FIDUCIARY**

The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Employer, who is the sponsor of this Plan.

In exercising its fiduciary responsibilities, the Employer shall have sole, full and final discretionary authority to determine eligibility for benefits, review denied claims for benefits, construe and interpret all Plan provisions, construe disputed Plan terms, select managed care options, determine all questions of fact and law arising under this Plan, and to administer the Plan's subrogation and reimbursement rights. The Employer shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**OPEN ENROLLMENT**

Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer. See the Key Information section at the beginning of this document for applicability, as well as Your Employer for details.

**OUT-OF-NETWORK RATE**

With regard to services that are subject to balance billing protections (see the "Out-of-Network Benefits" section for more detail), the Out-of-Network Rate is the amount used to calculate the benefit payable to the out of network provider for Covered Services. The Out-of-Network Rate will equal (i) the Recognized Amount, (ii) an amount agreed to by the Plan and the provider, (iii) or the amount determined payable in accordance with the independent dispute resolution process set forth in section 716(c) or 717(b) of ERISA.

**OUT-OF-POCKET MAXIMUM**

The "Out-of-Pocket Maximum" is the total amount of co-pays, co-insurance and deductibles for which the Covered Person or covered family is responsible during the course of a Calendar Year. These amounts are shown in the "Schedule of Covered Services and Provisions," along with expenses not applicable towards the Out-of-Pocket maximum. Once this amount has been reached, 100% level of benefits applies for the remainder of that Calendar Year.

**OUTPATIENT**

A Covered Person shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 23 consecutive hours.

**PHYSICIAN**

A Physician who is duly qualified and licensed and/or certified by the state in which he is resident to practice medicine, perform surgery and to prescribe drugs, or who is licensed to practice as a dentist, podiatrist, chiropractor, psychologist, social worker or practitioner of healing arts, and who is practicing within the scope of his license and/or certification.

**PLACEMENT FOR ADOPTION**

The assumption and retention of a legal obligation for total or partial support in anticipation of adoption.

**PLAN**

The benefits and provisions for payment of same as described herein are the Employer Plan as described in the Key Information section at the beginning of this document. This is a group health plan.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**PLAN ADMINISTRATOR**
The entity responsible for the day-to-day functions and overall management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services. The Plan Administrator is the Company.

**PLAN YEAR**
The 12-month period defined in the Key Information section at the beginning of this document. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section.

**QUALIFIED MEDICAL CHILD SUPPORT ORDER**

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If Your employer determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO, and Your current plan offers dependent coverage, You will be required to provide coverage for any child(ren) named in the QMCSO. If You do not enroll the child(ren), Your employer must enroll the child(ren) upon application from Your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from Your pay Your share of the cost of such coverage. You may not drop coverage for the child(ren) unless You submit written evidence to Your employer that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). ERISA preemption of state laws does not apply to Qualified Medical Child Support Orders and provisions of state laws requiring medical child support. Group health plans may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning "QMCSO" procedures are available from the Plan Administrator at no charge upon request.

**REASONABLE/REASONABLENESS**

"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or charges for services or supplies, which are necessary for the care and treatment of Illness or Injury. Determination that charges or services/supplies 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/or the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination may consider, but not be limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, services, supplies and/or charges must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether services, supplies and/or charges are Reasonable based upon information presented to the Plan Administrator.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

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

**RECOGNIZED AMOUNT**

For purposes of Covered Services that are subject to balance billing protections (see the "Out-of-Network Benefits" section for more details), the Recognized Amount is the amount used to calculate the Covered Person's cost share for such services. The Recognized Amount is typically the lesser of the billed charge or the qualifying payment amount. The methodology for determining the qualifying payment amount is set by federal regulations at 29 CFR 2590.716-6, and is adjusted from time to time*.

**RECONSTRUCTIVE BREAST SURGERY COVERAGE**

Medical benefits under the Plan will be administered according to the terms of the Women's Health and Cancer Rights Act of 1998. The Plan will provide to Covered Persons who are receiving Plan benefits in connection with such mastectomy coverage for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. The coverage will be subject to the terms of the Plan established for other coverage under the Plan, including the annual deductible and coinsurance provisions.

**RETIREE**

See the Key Information section at the beginning of this document.

**SECOND SURGICAL OPINION**

Shall mean a written statement on the necessity for the performance of a covered surgical procedure. This Second Surgical Opinion must be given by a board-certified specialist who, by the nature of the Physician's specialty, qualifies the Physician to consider the surgical procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the surgery.

**SPECIAL ENROLLMENT**

An enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See "Eligibility" section for details.

*In some situations, different rules will apply and the Recognized Amount, as defined by federal rules at 29 CFR 2590.2590.716-3, will be used instead. The Recognized Amount takes into account whether a particular state has adopted an all-payer model agreement, or whether state law applies for setting fees. If neither an all-payer model agreement nor state law legally applies, the Recognized Amount would, in most cases, be the lesser of the qualifying payment amount or the amount the non-network provider actually billed.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**USUAL AND CUSTOMARY**

"Usual and Customary" (U&C) shall mean Covered Services which are identified by the Plan Administrator, taking into consideration the charge(s) which the provider most frequently bills the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the prevailing range of charges billed in the same "area" by providers of similar training and experience for the service or supply, and/or 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, service, or supply for which a specific charge is made. To be Usual and Customary, the charge must be in compliance with the Plan Administrator's policies and procedures relating to 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 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 Covered Person by a provider of services or supplies. 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.

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, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

**WAITING PERIOD**

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period.

**YOU, YOUR, YOURSELF**

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Company employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# ELIGIBILITY

## WHO IS ELIGIBLE

See the Key Information section at the beginning of this document.

## NON-DISCRIMINATION

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

## EMPLOYEE COVERAGE

For date of eligibility, please see the Key Information section at the beginning of this document. Providing a new employee is actively at work on at least the first day of employment, the Plan will not exclude absences from work due to health-related reasons from credit towards the waiting period, if applicable, as referenced in the Key Information section.

## DEPENDENT COVERAGE

Each Dependent of the eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:

1. The date the Employee is eligible; or
2. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

## INDIVIDUAL EFFECTIVE DATE

All persons become covered, as they become eligible subject to the following:

1. All Employees, who are eligible Employees, shall be covered on the day they become eligible, as discussed in the Key Information section at the beginning of this document.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will begin from the date of Placement for Adoption. Coverage for a stepchild or foster

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

child will begin from the date the child meets the definition of "Dependent." With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 30 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 30 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date that the child meets the definition of "Dependent."

**OPEN ENROLLMENT**

See the Key Information section at the beginning of this document for applicability.

**LATE ENROLLMENT**

See the Key Information section at the beginning of this document for applicability.

**SPECIAL ENROLLMENT**

The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a late enrollee.

An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and lose that coverage. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance (CHIP) program with respect to this Plan.

If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended. Loss of eligibility includes a loss of coverage due to:

- divorce;
- legal separation;
- death;
- termination of employment, or reduction in hours of employment;

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals;
- the Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the employee or dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 30 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

**TERMINATION OF COVERAGE**

See the Key Information section at the beginning of this document for details.

# EMPLOYER POLICIES AND PROCEDURES

Except as required under the Americans with Disabilities Act, the Family and Medical Leave Act, or the Uniformed Services Employment and Reemployment Rights Act, or applicable state leave laws such as CFRA in California and OFLA in Oregon, the Employer's policies and procedures regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified disability, leave of absence, furlough, reinstatement, hire or rehire. Whether an Employee averages the requisite hours of service to be eligible for coverage shall be determined in accordance with the policies and procedures of the Employer.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

The Plan may not 1) deny a Qualified Individual participation in an Approved Clinical Trial, 2) deny (or limit or impose additional conditions on) coverage of Routine Patient Costs for items and services furnished in connection with the Approved Clinical Trial, or 3) discriminate against the Qualified Individual based on his/her participation in the Approved Clinical Trial. However, if the Plan has a network of providers and one or more network providers is participating in an Approved Clinical Trial, the Qualified Individual must participate in the Approved Clinical Trial through such network provider if the provider will accept the Qualified Individual as a participant in the trial. This requirement to use network providers will not apply to a Qualified Individual participating in an Approved Clinical Trial that is conducted outside the state in which the Qualified Individual resides (unless the Plan does not otherwise provide out-of-network coverage generally).

The following definitions are applicable under this provision:

**Qualified Individual**

A Covered Person who meets the following conditions:

A. The Covered Person is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition, and

B. Either:

- The referring health care professional is a participating health care provider and has concluded that the Covered Person's participation in such trial would be appropriate, or
- The Covered Person provides medical and scientific information establishing that the Covered Person's participation in such trial would be appropriate.

**Approved Clinical Trial**

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, or Mental/Nervous and Substance Use Disorder Services, and is described in any of the following subparagraphs:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    1. The National Institutes of Health.
    2. The Centers for Disease Control and Prevention.
    3. The Agency for Health Care Research and Quality.
    4. The Centers for Medicare & Medicaid Services.
    5. A cooperative group or center of any of the entities described in clauses 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
7. Any of the following entities in clauses 7a. through 7c. below if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    a. The Department of Veterans Affairs.
    b. The Department of Defense.
    c. The Department of Energy.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

**Routine Patient Costs**

All items and services consistent with the coverage provided by the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. However, Routine Patient Costs do not include:

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

**Life-Threatening Disease or Condition**

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# NETWORK BENEFITS

Your Plan contains enhanced benefits through network providers. The name of the organization associated with these network providers is indicated on the front of Your ID card, along with instructions regarding where to file medical claims. Benefits are generally paid at a higher level when using network Hospitals and network Physicians than when using non-network providers. Please refer to the Schedule of Covered Services and Provisions for benefits payable according to type of provider used.

A Physician or Hospital's status within Your network can change. In order to access the most up-to-date list of in-network providers, visit alliedbenefit.com or call the customer service number on Your ID card.

**When Your Provider Leaves the Network**
If Your provider or facility is leaving/has left the Plan's network due to nonrenewal or expiration of the contract, the Plan will notify You. You, in turn, will need to notify the Plan if You require continuing transitional care with that provider or facility for certain serious or complex conditions, pregnancy, terminal illness, scheduled non-elective surgical care, or if You are undergoing Inpatient or institutional care. You may have a right to elect to continue transitional treatment and still be covered by the Plan under the same terms and conditions that existed when the provider or facility was part of the Plan's network. Such coverage would be temporary, up to a maximum of 90 days.

A Covered Person has a free choice of any provider for medical care. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan. Please see the "Out-of-Network Benefits" section for an explanation of notice and consent requirements for non-network providers.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# OUT-OF-NETWORK BENEFITS

This Plan is designed for You to receive maximum benefits through its network Hospitals and network Physicians. As set forth in the Schedule of Covered Services and Provisions, benefits are payable at a different level for non-network providers, and the Plan Administrator, in its sole discretion, uses various methodologies for determining the Plan's reimbursable amount for Covered Services from non-network providers. When You choose a non-network provider, You are responsible for paying, directly to the non-network provider, any difference between the reimbursable amount and the amount the provider bills You. This is called "balance billing."

**BALANCE BILLING PROTECTIONS**

For Covered Services received on or after January 1, 2022, new federal rules apply to the following services provided by an out of network provider or facility to prevent You from being balanced billed:

- *Emergency Room Services*.
- *Air Ambulance*.
- *Non-Emergency Care* when provided by a non-network provider at certain in-network facilities (i.e., a Hospital, a Hospital Outpatient department, a critical access Hospital, an Ambulatory Surgical Center, and any other facility specified by the Secretary of HHS) for the categories of service listed below:
    - Ancillary Services (see the Definitions section);
    - Non-Ancillary Services, if the non-network provider has not given proper notice and You've not given proper consent;

For the services above, the most a provider may bill You is Your Plan's in-network cost-sharing amount (co-pay, Coinsurance and/or Deductible) that is based on the Recognized Amount for such services.

Your out-of-pocket amounts for the above mentioned services will be applied to Your in-network limits (e.g. deduction and/or Out-of-Pocket Maximum).

A note about Notice and Consent (where required). In certain situations described above, You can still be balance billed by a non-network provider or facility so long as You receive proper notice, and You (or Your authorized representative's) consent to waive Your rights to balance billing protections prior to the Covered Service.

If You believe You have been wrongly billed, You may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit Your question or a complaint. You can also submit a complaint online at:
https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

Visit https://www.cms.gov/nosurprises for more information about Your rights under federal law.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# PROCEDURES FOR FILING CLAIMS

Remember to Pre-Certify by calling the toll-free number shown on Your ID card if required by Your Plan.

**KEY POINTS TO REMEMBER**

The claims filing address You must use for filing all medical claims is shown on Your ID card.

1. Each bill should be itemized as to services, show payment status, and include the name of the patient, the Employee's social security number or unique identification number ("UID"), and the name and/or group number of the Employer.
2. It is Your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
3. All charges, and corresponding requested documentation, must be submitted within the time frame specified in the Schedule of Covered Services and Provisions. Failure to do so will result in the denial of the charges.
4. From time to time, additional information may be requested to process Your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, accident details, police reports, etc. must be submitted by You or Your provider(s) when requested within the time frame specified in the Schedule of Covered Services and Provisions. Your failure to do so will result in the denial of the claim.
5. Only clean claims will be adjudicated by the Plan. A clean claim is one that is complete and accurate, does not require further information for processing from the provider, patient, or any other person or entity, and leaves no issues regarding the Plan's responsibility for payment.
6. Urgent care claims: The Plan will defer to the attending provider regarding the decision as to whether the claim constitutes an urgent care claim. Clean urgent care claims will be determined by the Plan as soon as possible (taking into account medical exigencies), but not later than 72 hours after receipt of the claim. For incomplete or incorrectly filed urgent care claims, You will be notified of the proper procedures to follow as soon as possible but no later than 24 hours after receipt of the claim.

**FILING A HOSPITAL CLAIM**

When a Covered Person is admitted as an Inpatient or is treated as an Outpatient, secure an itemized Hospital bill, including an admitting diagnosis. Check Your bill for any possible errors and then submit the charges as indicated above.

Always retain a copy of the hospital bill for Your records.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**MISCELLANEOUS CLAIMS FILING CONSIDERATIONS**

It is necessary to keep separate records of Your expenses with respect to each of Your Dependents and Yourself. The following items are important and should be carefully kept to be submitted with Your claim:

1. All Physician's bills should show the following:
    a. Name of patient and adequate membership information
    b. Dates and charges for services, and payment status of each
    c. Types of service rendered and procedure codes
    d. Diagnosis information

2. Prescription drug expenses should show the following:
    a. Name of patient and adequate membership information
    b. Prescription number and name of drug
    c. Cost of the drug and date of purchase. Cash register receipts and canceled checks cannot be accepted for payment.
    d. Generic Drugs should be indicated on the drug bill

3. Bills for all other covered medical charges, such as for ambulance service, durable medical equipment, etc. should show the following:
    a. Name of patient and adequate membership information
    b. Date of service
    c. Charge and description of each service/item
    d. Diagnosis information

Always retain a copy of the bill for Your records.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# THIS PLAN AND MEDICARE

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. If the Employee is still actively at work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
5. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# GENERAL PROVISIONS

## ADMINISTRATION OF THE PLAN

The Plan is administered through the Office of the Company. The Company has retained the services of an independent Claims Processor experienced in claims processing. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section at the beginning of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator at the address specified in the Key Information section at the beginning of this document.

## APPEALING A CLAIM

## CLAIMS PROCEDURES

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. A rescission is 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. An Adverse Benefit Determination is subject to the provisions detailed below.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.
- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal, the contact information for the Employee Benefits Security Administration (1-866-444-EBSA (3272)) to assist individuals with the first level claim and appeal process and second level (external) appeal process if applicable (see below), and a statement of claimant's right to bring a civil action under Section 502(a) of ERISA following a determination on appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

**FIRST LEVEL APPEALS PROCEDURE**

If You receive an Adverse Benefit Determination, You or Your authorized representative may appeal the determination by filing a written application with the Plan Administrator. In appealing an Adverse Benefit Determination, the Plan Administrator will provide You or Your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

**A first level appeal must be filed within 180 days after the Adverse Benefit Determination is received.** The Plan Administrator will notify You or Your authorized representative of its determination within 60 days after receipt of an appeal.

The Plan Administrator's determination:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.
- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Will contain a statement of Your right to bring an action under Section 502(a) of ERISA if a second level (external) review is inapplicable.
- Will contain a description of the Plan's second level (external) review process (applicable solely where the Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act), including information on how to initiate a second level appeal, and the contact information for the Employee Benefits Security Administration to assist individuals with the second level review process (1-866-444-EBSA (3272)), as well as a statement of Your right to bring a civil action under Section 502(a) of ERISA following the determination of the external review.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit 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.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the first level claims and appeals process with respect to a claim, You are deemed to have exhausted the first level claims and appeals process (unless the Plan's failure to strictly adhere to these requirements is 1) *de minimis*, 2) non-prejudicial, 3) attributable to good cause or matters beyond the Plan's control, 4) in the context of an ongoing good faith exchange of information, and 5) not reflective of a pattern or practice of non-compliance). Accordingly, upon such a failure, You may initiate a second level (external) review (see below) or, if not applicable, pursue any available remedies under applicable law.

To the extent the Plan contends that it did not commit a procedural violation based on the five criteria referenced immediately above, You will be entitled, upon written request, to an explanation of the Plan's basis for such an assertion (to be provided within ten days), so that You can make an informed judgment about whether to seek immediate review from an external reviewer or, if not applicable, a court of law. Finally, if the external reviewer or the court of law (as applicable) rejects Your request for immediate review on the basis that the Plan did not engage in a violation, You have the right to resubmit and pursue the first level claims and appeals process.

If the Plan denies Your first level appeal, in whole or in part, and You choose to bring a civil action, such action must be filed within 365 days of the date of the Plan's denial of Your first level appeal. This 365 day time period, however, will be temporarily suspended to the extent You are entitled to file a second level (external) appeal (see below) and do in fact file such an appeal. Under such circumstances, this 365 day time period will be suspended from the date You submit a request for a second level (external) appeal that is both complete and eligible until the date of the Independent Review Organization's decision (see below).

**SECOND LEVEL (EXTERNAL) APPEALS PROCEDURE**

If the Plan denies Your first level appeal, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or Your authorized representative may file a second level (external) appeal of the Final Internal Adverse Benefit Determination where the Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act. To file a second level appeal, You must file a written application with the Plan Administrator.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**A second level appeal must be filed within 4 months after the Final Internal Adverse Benefit Determination is received.** If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Plan reserves the right to charge a nominal filing fee, as allowed by applicable law.

**Preliminary review**. Within 5 business days following the date of receipt of the second level (external) review request, the Plan must complete a preliminary review of the request to determine whether:

a. The claimant is or was covered under the Plan at the time the health care service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care service was provided;

b. The Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act;

c. The claimant has exhausted the Plan's first level appeal process; and

d. The claimant has provided all the information and forms required to process a second level review.

Within one business day after completion of the preliminary review, the Plan must issue a notification in writing to the claimant. If the request is complete but not eligible for a second level review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the Plan must allow a claimant to perfect the request for the second level review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

**Referral to Independent Review Organization**. The Plan must assign an independent review organization ("IRO") to conduct the second level (external) review. The assigned IRO will timely notify the claimant in writing of the acceptance for the second level review. This notice will include a statement that the claimant may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the second level review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within 5 business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Final Internal Adverse Benefit Determination. If the Plan fails to timely provide the documents and information, the IRO may terminate the second level review and make a decision to reverse the Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

Upon receipt of any information submitted by the claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Final Internal Adverse Benefit Determination that is the subject of the second level review. The second level review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

making such a decision, the Plan must provide written notice of its decision to the claimant and the IRO. The IRO must terminate the second level review upon receipt of the notice from the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim without deference to the Plan and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider the following additional information:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from other health care professionals and other documents submitted by the Plan, claimant or claimant's treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, including evidence-based standards and other guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless such criteria are inconsistent with the terms of the Plan or applicable law; and
- The opinion of the IRO's clinical reviewer(s) to the extent the information or documents are available and the clinical reviewer(s) considers appropriate;

The IRO must provide written notice of its second level review decision within 45 days after it receives the request for the second level review. The notice must be provided to both the claimant and the Plan, and must include the following:

- A general description of the reason for the request for the review with enough information to identify the claim, and reason for the Final Internal Adverse Benefit Determination;
- The date the IRO received the assignment to conduct the second level review;
- The date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards used;
- A statement that the determination is binding, except to the extent other legal remedies may be available under Federal or state law to the Plan or claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

The IRO must maintain records of all claims and notices associated with the second level review process for 6 years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

**Reversal of the Plan's decision**. Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim.

For questions about Your appeal rights or for assistance, You can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

**ASSIGNMENT OF BENEFITS**

An arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits. Plan Participants cannot assign, pledge, borrow against or otherwise promise any benefits payable under the Plan before receipt of the benefit. However, benefits will be provided to a Participant's qualified dependent if required by a Qualified Medical Child Support Order or National Medical Support Notice. In addition, subject to the written direction of a Participant, all or a portion of benefits provided by the Plan may, at the option of the Plan and unless a Participant requests otherwise in writing, be paid directly to the person rendering such service. The payment of benefits directly to a provider of services, if any, is done as a convenience to the Plan Participant and does not constitute an assignment of rights or benefits under the Plan. Providers of services are not, and shall not be construed as, either "Participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants and beneficiaries under any circumstances. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Employer to the extent of such payment.

**CLAIM AUDIT**

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

**COMPLIANCE**

The Plan shall comply with all federally mandated benefit laws and regulations pertaining to employee benefit plans. The intent of the Plan is to assure full compliance with all appropriate federal laws, rules and regulations and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional. The Claims Processor shall be fully discharged from liability under this Plan.

**CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS**

Same as Employer.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**CONTRIBUTIONS**

The benefits provided under the terms of this Plan are purchased through Employer contributions. At the discretion of the Company, Employees may be required to contribute on a payroll deduction basis.

**ERISA AMENDMENTS**

Any provision of this Plan that is in conflict with ERISA, which governs this Plan, shall be deemed amended to conform to the minimum requirements of the law.

**FUNDING**

This Plan is a Company sponsored self-funded reimbursement program for the benefits described in the Key Information section at the beginning of this document.

**LIENS**

To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

**NO WAIVER**

A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

**PLAN IS NOT A CONTRACT**

The Plan shall not be deemed to constitute a contract between the Company and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

**PLAN AMENDMENT, MODIFICATION OR TERMINATION**

The Company reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Company. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

**PROHIBITION ON RESCISSION**

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

**REIMBURSEMENT AND SUBROGATION PROVISIONS**

**PAYMENT CONDITION**

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Illness, Injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, 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 "Coverage").

However, such payment of benefits by the Plan shall be made only if the Covered Person first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

The Covered Person (including his attorney, and/or legal guardian of a covered minor or incapacitated individual) 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 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 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. Further, by accepting benefits, the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person settles, recovers, or is reimbursed by any 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 (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who 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, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

**SUBROGATION**

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,

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as applied to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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 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.

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.

**RIGHT OF REIMBURSEMENT**

The Plan shall have the specific right of first recovery ("reimbursement"), and as such, 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 equitable and/or legal theory, without regard to whether the Covered Person is fully compensated by his 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

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

as including medical, disability, or other expenses. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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, express written consent of the Plan.

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.

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.

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, injury, disease or disability.

**COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS**

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Covered Person understands that he/she is required to:

a) notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

c) in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

d) hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

To the extent the Covered Person disputes his/her obligation to the Plan under this section, the Covered Person or any of his/her agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from his/her general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

**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(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(s), 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.

**WRONGFUL DEATH**

In the event that the Covered Person dies as a result of his injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

**OBLIGATIONS**

It is the Covered Person's 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 Illness, Injury, or disability, 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, including providing to the Plan an executed reimbursement agreement;

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 Covered Person may have against any responsible party or Coverage.

If the Covered Person and/or his 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

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

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's cooperation or adherence to these terms.

**OFFSET**

Failure by the Covered Person and/or his 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 obligation.

**MINOR STATUS**

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 estate insofar as these subrogation and reimbursement provisions are concerned.

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.

**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.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

**RIGHTS OF RECOVERY**

Whenever payments have been made by the Plan which are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Claims Processor or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**SEVERABILITY**

Should any provision of this Summary Plan Description be declared invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining portions of the Summary Plan Description. Any remaining portions shall remain in full force and effect, as if this Summary Plan Description did not contain the invalid or illegal provision.

**SUBMISSION OF CLAIM**

All charges, and corresponding requested documentation, must be submitted by the date specified in the Schedule of Covered Services and Provisions. Failure to do so will result in the denial of the charges.

**SUMMARY OF MATERIAL MODIFICATIONS**

Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in Covered Services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

**SUMMARY PLAN DESCRIPTION**

The Company will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is intended to satisfy the requirement for both a Summary Plan Description and Plan Description as specified under ERISA.

**SYSTEM FOR PROCESSING CLAIMS**

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, Reasonable and/or Usual and Customary limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

**TYPE OF ADMINISTRATION**

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Processor to process claims and provide consulting services and ministerial functions.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. See Schedule of Covered Services and Provisions to determine the type of Coordination of Benefits this Plan provides.

To coordinate benefits, it is necessary to determine in what order the benefits of various Plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

   If the parent with custody has not remarried:

   a) The plan of the parent with custody is primary.
   b) The plan of the parent without custody is secondary.

   If the parent with custody has remarried:

   a) The plan of the parent with custody is primary.
   b) The plan of the stepparent with custody is secondary.
   c) The plan of the parent without custody is tertiary (third).

   There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.
5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

To the extent that the Plan would be secondary to Medicare, if a Covered Person is eligible for Medicare Part A and/or Part B and does not elect to enroll in such Medicare coverage, then Plan benefits will be coordinated based on an estimate of what Medicare would have paid, regardless of whether benefits are actually received from Medicare.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Any other “plan” means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee, Employee benefit association, government agency or professional association; or any homeowner’s policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any individual or non-group health coverage, of which the Plan Administrator is actually aware, including but not limited to a plan or policy purchased or made available through a state or federally managed Health Insurance Marketplace; or any coverage provided by a licensed Health Maintenance Organization (HMO); or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term “plan” shall also mean any mandatory “no-fault” automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident; and any other payment received under any automobile policy.

To administer this provision, the Company has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party, when the Company should have made the payment.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# COMPLIANCE REGULATIONS

## STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain pre-certification. For information on pre-certification, contact Your Plan Administrator.

## SOURCE OF INJURY RESTRICTIONS

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

## WELLNESS VS. RISK FACTORS

The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

## FAMILY MEDICAL LEAVE ACT (FMLA)

### The following applies to companies with 50 or more employees

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Company that the Covered Person does not intend to return to work at the end of the FMLA leave.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

The Covered Person may choose not to retain health coverage during the FMLA leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA leave.)

**MILITARY LEAVES**

If You are absent from work due to military service, You may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date You are required to apply for or return to active employment with Your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if You are absent for 30 days or less, Your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that You had not fully completed any required waiting period prior to the start of military service.

**GENETIC INFORMATION**

The Plan may not adjust premium or contribution amounts for those covered under the Plan on the basis of genetic information. The Plan may also not request, require or purchase genetic information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no genetic information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

## INTRODUCTION

This notice contains important information about Your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You and other members of Your family when group health coverage would otherwise end. For more information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

## WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a “qualifying event”. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You're an employee, You'll become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

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

If You're the spouse of an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

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

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**WHEN IS COBRA COVERAGE AVAILABLE?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.**

**HOW IS COBRA COVERAGE PROVIDED?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18 month period of COBRA continuation coverage can be extended.

**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 notify the Plan Administrator in a timely fashion, 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. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

**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 the Plan is properly notified about 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.

**ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?**

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.HealthCare.gov.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

You should compare Your other coverage options with COBRA continuation coverage and choose the coverage that is best for You. For example, if You move to other coverage You may pay more out of pocket than You would under COBRA because the new coverage may impose a new deductible.

When You lose job-based health coverage, it's important that You choose carefully between COBRA continuation coverage and other coverage options, because once You've made Your choice, it can be difficult or impossible to switch to another coverage option.

**WHAT IS THE HEALTH INSURANCE MARKETPLACE?**

The Marketplace allows You to find and compare private health insurance options. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums and cost-sharing reductions (amounts that lower Your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Through the Marketplace You'll also learn if You qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for Your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage.

**WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?**

You always have 60 days from the time You lose Your job-based coverage to enroll in the Marketplace. That is because losing Your job-based health coverage is a "special enrollment" event. **After 60 days Your special enrollment period will end and You may not be able to enroll, so You should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what You need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

**IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?**

If You sign up for COBRA continuation coverage, You can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end Your COBRA continuation coverage early and switch to a Marketplace plan if You have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if You terminate Your COBRA continuation coverage early without another qualifying event, You'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Once You've exhausted Your COBRA continuation coverage and the coverage expires, You'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If You sign up for Marketplace coverage instead of COBRA continuation coverage, You cannot switch to COBRA continuation coverage under any circumstances.

**WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?**

When considering Your options for health coverage, You may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If You're currently getting care or treatment for a condition, a change in Your health coverage may affect Your access to a particular health care provider. You may want to check to see if Your current health care providers participate in a network as You consider options for health coverage.
- Drug Formularies: If You're currently taking medication, a change in Your health coverage may affect Your costs for medication – and in some cases, Your medication may not be covered by another plan. You may want to check to see if Your current medications are listed in drug formularies for other health coverage.
- Severance payments: If You lost Your job and got a severance package from Your former employer, Your former employer may have offered to pay some or all of Your COBRA payments for a period of time. In this scenario, You may want to contact the Department of Labor at 1-866-444-3272 to discuss Your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if You move to another area of the country, You may not be able to use Your benefits. You may want to see if Your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, You probably pay copayments, deductibles, coinsurance, or other amounts as You use Your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

**IF YOU HAVE QUESTIONS**

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under the Employee Retirement Income Security Act (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) in Your area 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.) For more information about the Marketplace, visit www.HealthCare.gov.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

In order to protect Your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You sent to the Plan Administrator.

**PLAN CONTACT INFORMATION**

If You have any questions regarding COBRA Continuation Coverage under the Plan, please contact Your Plan Administrator.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# ERISA RIGHTS SECTION

As a Plan Participant, You are entitled to certain rights and protection 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 the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Services Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**CONTINUE GROUP HEALTH PLAN COVERAGE**

Continue health care 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 may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

**PRUDENT ACTIONS BY PLAN FIDUCIARIES**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the 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, Your union, 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 benefit is denied or ignored, in whole or in part, or if Your coverage was rescinded, You have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

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 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, or if Your coverage was rescinded, You may file suit in a state or Federal court, subject to the procedures discussed in the Section "APPEALING A CLAIM" under "GENERAL PROVISIONS." In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's 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.

**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 Services Administration (EBSA), U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Services 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 EBSA.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS")

## ISSUED PURSUANT TO

**The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA")**

**1. Disclosure of Summary Health Information to the Plan Sponsor**

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

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

**2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes**

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

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);

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

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

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

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

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

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

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

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

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

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

    i. The access to and use of PHI by the individuals described in the Key Information section at the beginning of this document shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

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

"Plan Administration" functions are activities that would meet the definitions of treatment, payment and health care operations. "Plan Administration" functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, medical necessity reviews, certain appeal determinations, utilization review, case management and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

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

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**3. Disclosure of Certain Enrollment Information to the Plan Sponsor**

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

**4. Other Disclosures and Uses of PHI**

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

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT COVERED PERSONS MAY BE USED AND DISCLOSED AND HOW COVERED PERSONS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan's legal obligations concerning a Covered Person's protected health information and describes a Covered Person's rights to access, amend and manage that protected health information.

Protected health information ("PHI") is individually identifiable health information, including demographic information, collected from a Covered Person or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Person's past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Person; or (3) the past, present or future payment for the provision of health care to a Covered Person.

This Notice has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document:

**THE PLAN'S RESPONSIBILITIES**

The Plan is required by law to maintain the privacy of a Covered Person's PHI. The Plan is obligated to provide the Covered Person with a copy of this Notice of the Plan's legal duties and of its privacy practices with respect to the Covered Person's PHI, abide by the terms of the Notice that is currently in effect, and notify the Covered Person in the event of a breach of the Covered Person's unsecured PHI. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

**PERMISSIBLE USES AND DISCLOSURES OF PHI**

The following is a description of how the Plan is most likely to use and/or disclose a Covered Person's PHI.

**TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

**TREATMENT**

The Plan will use or disclose PHI so that a Covered Person may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between one or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's primary care physician so that the specialist may request medical records from that primary care physician.

**PAYMENT**

The Plan will use or disclose PHI to pay claims for services provided to a Covered Person and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

**HEALTH CARE OPERATIONS**

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

**POTENTIAL IMPACT OF STATE LAW**

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

**OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI**

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

**REQUIRED BY LAW**

The Plan may use or disclose PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

**PUBLIC HEALTH ACTIVITIES**

The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

**HEALTH OVERSIGHT ACTIVITIES**

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

**ABUSE OR NEGLECT**

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Covered Person's PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**LEGAL PROCEEDINGS**

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

**LAW ENFORCEMENT**

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

**CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION ORGANIZATIONS**

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

**RESEARCH**

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

**TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY**

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

**MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES**

Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

**INMATES**

If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Person; (2) the Covered Person's health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

**WORKERS' COMPENSATION**

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

**EMERGENCY SITUATIONS**

The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

**FUNDRAISING ACTIVITIES**

The Plan may use or disclose the PHI of a Covered Person for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does contact the Covered Person for fundraising activities, the Plan will give the Covered Person the opportunity to opt-out, or stop, receiving such communications in the future.

**GROUP HEALTH PLAN DISCLOSURES**

The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Covered Person. The Plan can disclose the PHI of the Covered Person to that entity if that entity has contracted with the Plan to administer the Covered Person's health care program on its behalf.

**UNDERWRITING PURPOSES**

The Plan may use or disclose the PHI of a Covered Person for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Covered Person for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI of the Covered Person that is genetic information.

**OTHERS INVOLVED IN YOUR HEALTH CARE**

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

## REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

### DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

### DISCLOSURES TO COVERED PERSONS

The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: (1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

### BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

**OTHER COVERED ENTITIES**

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

**PLAN SPONSOR**

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

**USES AND DISCLOSURES OF PHI THAT REQUIRE A COVERED PERSON'S AUTHORIZATION**

**SALE OF PHI**

The Plan will request the written authorization of a Covered Person before the Plan makes any disclosure that is deemed a sale of the Covered Person's PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

**MARKETING**

The Plan will request the written authorization of a Covered Person to use or disclose the Covered Person's PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Covered Person or when the Plan provides promotional gifts of nominal value.

**PSYCHOTHERAPY NOTES**

The Plan will request the written authorization of a Covered Person to use or disclose any of the Covered Person's psychotherapy notes that the Plan may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Person's written authorization. If the Covered Person provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

## A COVERED PERSON'S RIGHTS

The following is a description of a Covered Person's rights with respect to PHI:

### RIGHT TO REQUEST A RESTRICTION

A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations. The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send the request when the Covered Person's call is received. In this request, it is important that the Covered Person states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

### RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Covered Person believes that a disclosure of all or part of his PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

The Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

(2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document as soon as the Covered Person determines the need to restrict disclosures of his PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

**RIGHT TO INSPECT AND COPY**

A Covered Person has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a request by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Person

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. If a Covered Person is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A licensed health care professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

**RIGHT TO AMEND**

If a Covered Person believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Person may request that the Plan amend such information by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. Additionally, this request should include the reason the amendment is necessary. It is important that the Covered Person direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Person has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

**RIGHT OF AN ACCOUNTING**

The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Covered Person may request an accounting by submitting a request in writing to the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

Covered Person direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

**RIGHT TO A COPY OF THIS NOTICE**

The Covered Person has the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. If You receive this Notice on the Plan's website or by electronic mail, You also are entitled to request a paper copy of this Notice.

**COMPLAINTS**

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A copy of a complaint form is available from this contact office.

A Covered Person also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Covered Person became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

Docusign Envelope ID: 3B6C6766-7A25-4EA8-8061-F11477939EAD

# STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "SECURITY STANDARDS")

## 1. DEFINITIONS

a. The term "Electronic Protected Health Information" ("EPHI") has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.

b. The term "Security Incidents" has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

## 2. PLAN SPONSOR OBLIGATIONS

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and

d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and

ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

Paramount Dental Plan

Forest River In Network area
Group Number 379280325020

# Certificate of Coverage

PARAMOUNT DENTAL
*Affiliate of ProMedica*

Insurance products are marketed by Paramount Dental and underwritten and administered by Health Resources Inc.

This Handbook along with your Summary of Dental Plan Benefits, describes the specific benefits of your Paramount Dental Plan and how to use them.

Visit Paramount Dental Online 24 hours a day/7 days a week at InsuringSmiles.com

Contact Member Services
Paramount Dental
7:00 am – 7:00 pm CST Monday through Friday 800.727.1444
P.O. Box 659, Evansville, IN 47704-0659

# DENTAL PLAN HANDBOOK & CERTIFICATE OF INSURANCE

| | |
|---|---|
| Welcome to Your Paramount Dental Plan | 4 |
| Definitions | 4 |
| Eligibility | 7 |
| Enrollment Periods | 7 |
| Web Services | 8 |
| Member ID Card | 8 |
| Benefit Categories - What is Covered by my Plan? | 8 |
| Coinsurace | 9 |
| Plan Features | 9 |
| Service Exclusions | 10 |
| Service Limitations | 11 |
| Disallowed Services | 14 |
| How Payment Is Made | 14 |
| Notice of Claim | 15 |
| Claim Forms | 15 |
| Proof of Loss | 15 |
| Time of Payment of Claims | 16 |
| Legal Actions | 16 |
| Coordination of Benefits | 16 |
| Right of Recovery | 18 |
| Termination of Coverage | 18 |
| Continuation of Coverage | 18 |
| Questions and Assistance | 20 |
| General Conditions and Additional Information | 20 |
| Entire Contract & Changes | 20 |
| Claims Appeal Procedure | 20 |
| Notice of Privacy Practices | 21 |
| Physical Examinations and Autopsy | 22 |
| ERISA | 22 |
| Grace Period | 22 |
| Notification to Insureds | 23 |
| Misstatement of Age | 23 |
| Incontestability | 23 |
| Conformity with State Statutes | 23 |
| Benefit Details | 24 |
| Plan General Exclusions, Limitations and Restrictions | 45 |
| Orthodontic Benefit Rider | 55 |

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY

Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary of Dental Plan Benefits conflicts with a statement in this Certificate, the statement in the Summary of Dental Plan Benefits applies to this plan and you should ignore the conflicting statement in this Certificate.

## Language Assistance

| | |
|---|---|
| **English** | ATTENTION: If you speak English, free language assistance services are available. Call 1-800-727-1444 (TTY: 711). |
| **Español**<br>Spanish | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-727-1444 (TTY: 711). |
| **繁體中文**<br>Chinese | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-727-1444 (TTY 711）。 |
| **Tiếng Việt**<br>Vietnamese | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-727-1444 (TTY: 711). |
| **Tagalog**<br>Tagalog – Filipino | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-727-1444 (TTY: 711). |
| **한국어**<br>Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-727-1444 (TTY: 711) 번으로 전화해 주십시오. |
| **العربية**<br>Arabic | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1444 -727-800-1<br>(رقم هاتف الصم والبكم: 711) |
| **Հայերեն**<br>Armenian | ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-727-1444 (TTY (հեռատիպ)՝ 711): |
| **Русский**<br>Russian | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-727-1444 (телетайп: 711). |
| 日本語<br>Japanese | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-727-1444（TTY: 711）まで、お電話にてご連絡ください。 |
| **فارسی**<br>Farsi | **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-727-1444 (TTY: 711) تماس بگیرید. |
| **ਪੰਜਾਬੀ**<br>Panjabi | ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-727-1444 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। |
| **ខ្មែរ**<br>Cambodian | ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-727-1444 (TTY: 711)។ |
| **Hmoob**<br>Hmong | LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-727-1444 (TTY: 711). |
| **हिंदी**<br>Hindi | ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-727-1444 (TTY: 711) पर कॉल करें। |
| **Deutsch**<br>German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-727-1444 (TTY: 711). |
| **ภาษาไทย**<br>Thai | เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-727-1444 (TTY: 711). |
| **Deitsch**<br>Pennsylvania Dutch | Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-727-1444 (TTY: 711). |
| **ܣܘܪܝܝܐ**<br>Syriac | ܫܝܢܐ ܠܟ ܕܡܢ ܫܘܠܛܢܐ ܐܝܬ ܠܟ ܫܝܫܬ ܫܘܠܛܢ ܕܡܫܬܡܫ ܒܠܫܢ

## Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

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

Paramount provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Paramount Member Services at 1-800-727-1444, for TTY users, 711, 7:00 a.m. to 7:00 p.m. CST, Monday through Friday.

If you believe that Paramount has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by phone, mail, fax, or email.

Paramount Dental
1449 Kimber Lane
Ste 103
Evansville, IN 47715

Phone: 1-800-727-1444
TTY: 711
Fax: 812-401-3609
Email: Claims@InsuringSmiles.com

If you need help filing a grievance, Member Services is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW
Room 509F, HHH Building Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

# Welcome to Your Paramount Dental Plan

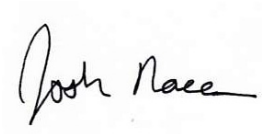
Thank you for enrolling in Paramount Dental! Oral health is a vital part of overall health, and it is our pleasure to be included in your wellness culture. Paramount Dental collaborates with the dental profession to design dental plans that promote oral health care along the most cost effective path. As any dental care professional will attest, the key to avoiding costly dental problems is prevention which starts with you and utilizing the preventive benefits included in your plan. We recommend making your first appointment as soon as possible to ensure you are on the road to great oral health!

You have a wide choice of Network Dentists, both generalists and specialists, nationwide! Network Dentists submit claim forms for services performed for you and payments are paid directly to them. Network Dentists also sign contracts with Paramount Dental to accept certain agreed upon fees, therefore, you and your employer may realize significant savings.

Paramount Dental is also committed to providing the highest quality member services to all Members. Our dedicated team members are available toll-free, Monday through Friday. You may also access information through our website, InsuringSmiles.com. It is your responsibility to be informed about Your Benefits and any associated Limitations and Restrictions, so please read and save this booklet for reference.

Our mission is to offer dental plans that "Improve Your Health and Well-Being". Since 1986, that is exactly what we have delivered to Our Members. We look forward to continuing that promise to our customers.

Sincerely,



Joshua Nace
President - Paramount Dental

This Certificate of Coverage (referred to herein as Certificate) is part of the Master Group Policy that is a legal document (a contract) between Paramount Dental and the Employer. (Referred to herein as We, Us, Our, Paramount Dental, or the Company) and Your Employer Group (referred to herein as Employer) to provide Benefits to Eligible Members (referred to herein as you or your) and is subject to the terms, conditions, Limitations and Exclusions of the Policy. Reasonable effort has been made for this Certificate to represent the intent of the Master Group Policy language between Paramount Dental and Your employer.

Paramount Dental issues this Certificate based on Your Employer Group's Master Group Policy and payment of the required Policy charges. In addition to this Certificate, the Policy includes:

- The Master Group Policy
- Employer Application
- The Summary of Dental Plan Benefits
- Riders
- Amendments

# Definitions

**Adverse Determination**
Any denial, reduction or termination, or a failure to provide or to make payment (in whole or part) of the benefit sought.

**Balance Billing**
Network Dentists agree to accept the network's contracted fees as payment in full. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as "balance billing" and is not enforceable for Out-Of-Network Dentist as they are under no obligation to limit their fees.

**Benefits**
The amounts that the Plan pays for Covered Services under a Member's dental Plan. Benefits may be available whether through teledentistry or face-to-face with your Dentist.

**Benefit Plan Year**
The plan year, unless your employer or organization elects a different period to serve as the Benefit Year.
(See the Summary of Dental Plan Benefits for your Benefit Year.)

**Children or Child**
Your natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with you during the waiting period for adoption or legal guardianship.

**Claim/Claim Form**
Standard statement of dental services performed that is submitted by a Dentist or Member to request payment from the Payor. Network dentists always file claim forms on behalf of members and accept payment directly from the Payor. Claim forms are also used to request a pretreatment estimate.

**Completion Dates**
The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;

- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

**Copayment / Coinsurance**
The Member's share, expressed as a fixed percentage, of the covered dental service.

**Coordination of Benefits (COB)**
A process that carriers use to determine the order of payment and amount each carrier will pay when a person receives dental services that are covered by more than one benefit plan. COB ensures that no more than 100 percent of the lowest allowable charges for services are paid when a member has coverage under two or more benefits plans (dual coverage) – for example, a child who is covered by both parents' plans.

**Covered Services**
Dental care services for which a reimbursement is available under a Member's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

**Custodial Parent**
The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the plan year excluding any temporary visitation.

**Deductible**
The amount a person and/or a family must pay toward Covered Services before Paramount Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

**Deny/Denied**
If a service is denied, the service is not considered a benefit of the patient's coverage and the allowable amount is collectible from the patient.

**Dentist**
Dental care provider who is skilled in and licensed to practice the prevention, diagnosis, and treatment of diseases, injuries, and malformations of the teeth, jaws, and mouth and who makes and inserts false teeth.

**Dependent/Dependent Child**
Any Member of a Subscriber's family who meets all the applicable Eligibility requirements, has been enrolled in the plan and for whom the payment required by the employer's group agreement has been received by Paramount Dental.

Dependent Child may include the enrolled employee's biological child, stepchildren, adopted children placed with the enrolled employee whether or not the adoption is final, foster children, children subject to legal court or administrative order to provide health coverage.

Dependent Child also includes any child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. We reserve the right to require proof of incapacity, but not more than annually following the two year period after the child attains limiting age.

**Disallow(ed)**
If a service is disallowed, the fee is not collectible from the patient by a Network Dentist or the plan.

**Effective Date**
The date a dental benefits policy begins. Effective date may also be used to describe the date that benefits begin for a Member. The Effective Date is determined in accordance with waiting periods and employment terms enforced by the employer group and applicable State and Federal regulatory entities.

**Eligibility**
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer.

**Eligible Persons –**
**(Employees + Spouses + Dependents)**
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer. Generally, Eligible persons typically include your legal spouses and dependents.

Paramount Dental will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. Dependent children are subject to the employer group's dependent age limitation, which must be no less than age 26.

Dependent child may include the Enrolled Employee's biological children, stepchildren, adopted children, foster children, children subject to legal guardianship, newborn children, or any child for whom the Member is the legal guardian or is required by a court or administrative order to provide health coverage. Coverage for adopted children is effective upon the earlier of: the date of placement or the date of entry of an order granting custody.

**Exclusions**
Services that are not covered under the Employer Group Dental Insurance Plan.

**Explanation of Benefits (EOB)**
The statement received after a claim is processed, detailing how Your claim was processed, including

identification of services rendered, fees, application of plan Limitations, calculation of Plan payment, and the amount for which you are responsible.

### Fee Charged
The amount that the Dentist bills and is entered on a claim as the charge for a specific service.

### Handbook
This document. Paramount Dental will provide Benefits as described in this Handbook. It also serves as your Certificate of Coverage. Any changes in this Handbook will be based on changes to the contract, including the Summary Plan Dental Benefits, between Paramount Dental and your employer or organization.

### Lifetime Maximum
The cumulative dollar amount that a plan will pay for dental care incurred by an individual Member for the life of the Member. Lifetime maximums usually apply to specific services such as orthodontic treatment.

### Limitations
A list of conditions or circumstances that limit or exclude services from Plan coverage.

Limitations may be related to time or frequency (the number of services permitted during a stated period).

### Master Group Policy
The written, legally binding agreement between Paramount Dental and an Employer Group.

### Maximum Allowable Amount
The maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meets our definitions of a Covered Service. The maximum allowable/expense is determined by a) the lesser fee of the primary or secondary insurance carrier as it applies to network participation, associated agreed discounts and patient responsibility or b) the fee considered for the global service. For network Dentists, this is the dollar amount that the attending Dentist has agreed to accept as payment in full for the plan and the patient. This amount is shown on the notice that accompanies payment of the claim.

### Maximum Allowable Fee
The Maximum Allowable fee amount is the maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meet our definitions of a Covered Service. For Network participating Dentists, the Maximum Allowed Amount will be reimbursed according to a Schedule of Maximum Allowable Charges. Unless specified within the Summary of Dental Plan Benefits of this Policy, the Maximum Allowed Amount for Out-Of-Network Dentists will be reimbursed according to a Table of Allowances as specified in your Summary of Plan Benefits. Paramount Dental's portion of payment for each covered service is the lesser of the Dentist's fee or the maximum allowable fee, minus the co-insurance.

### Plan Annual Maximum Benefit
The total maximum dollar amount the Employer Group Paramount Dental Plan will pay toward the cost of dental care incurred by an individual Member in a Plan Year.

### Member
A person covered under the Employer Group Paramount Dental Plan. There are two subsets of Members: The Primary Member who is the Employer Group Member under whom the family is enrolled, and the enrolled family members including spouse, domestic partner and eligible children.

### Network Dentist
A dentist who contracts with Paramount Dental or leased network carrier and agrees to accept contracted fees as payment in full and abide by certain administrative guidelines.

### Network
A panel of Dentists that contractually agree to provide treatment according to administrative guidelines, including limits to the fees accepted as payment in full.

### Open Enrollment Period
A period (usually a two-week or one-month period during the year) when qualified individuals (eligible employees) can enroll in or change their choice of coverage in-group benefits plans.

### Out of Network Dentist
A dentist who does not contract with Paramount Dental to participate in the network and the associated administrative guidelines including claim submission requirements and maximum allowable fee capitations.

### Patient Responsibility
The portion of a Dentist's fee that a Member must pay for dental services, including deductible, coinsurance, any amount over plan maximums, services the plan does not cover and covered services for which the patient is not eligible.

### Plan Administrator
The Employer/Sponsor of the Plan or such third party hired by the Employer/Sponsor who performs certain activities for the Plan.

### Pre-Authorization
A requirement that recommended treatment must first be approved by the Plan before the treatment is rendered in order for the Plan to pay benefits for those Covered Services.

### Premiums

The money billed and paid to Paramount Dental for each month of dental coverage. Payment must be made by an Employer group in order for claims to be paid.

**Pre-Treatment Estimate**
A non-binding estimate of the benefits available and patient responsibility for a proposed treatment plan after the application of Plan Limitations, restrictions, and exclusions, remaining plan annual maximum and determination of Covered Services.

**Qualifying Event**
Change in marital status, change in the number of dependents, or change in employment status.

**Resin/Composite**
Tooth-colored filling material. Although cosmetically superior, it is less durable than other materials.

**Submitted/Billed Amount**
The amount a Dentist bills to Paramount Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the amount Paramount Dental approves for the treatment.

**Subscriber**
You, when your employer or organization notifies Paramount Dental that you are eligible to receive Benefits under This Plan.

**Summary of Dental Plan Benefits**
A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

**Waiting Period for Plan Eligibility and For Covered Services**
Waiting periods are designated by an Employer Group. If an Employer Group establishes a plan-waiting period, it is the stated period of time that a Member must be enrolled in the Plan before being eligible for benefits or for a specific category of benefits. A waiting period limits reimbursement for various services until the insured has been covered for a specific amount of time. Waiting period can apply to specific/individual procedures as well as at the group level.

# Eligibility

Paramount Dental is available through employers for their employees. Your Employer selected the Plan and the level of coverage available for You and Your dependents. Coverage provided under the Plan for Employees and their Dependents shall be in accordance with their Eligibility, Effective Date, and Termination provisions of the Plan, including any coverage classifications. For more information, please contact Your Benefits Administrator.

Paramount Dental. Will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight.

**Qualified Medical Child Support Order (QMCSO)**
Under certain circumstances, You might be required to provide coverage for a child even if You do not have custody, or if the child is not Your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMSCO). An Employee who is ordered by a QMSCO to provide dental coverage for a child may enroll himself and such child under the Plan. If Your spouse also has dental insurance, he/she may enroll under your plan but special rules apply (see Coordination of Benefits).

**Extended Coverage for a Dependent Child**
Paramount Dental will acknowledge each individual Employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. If You have dependent(s) with a permanent physical disability or mental disability to the extent they cannot support themselves, they may qualify for coverage beyond the applicable age limit for dependent(s). In order to extend coverage, You must provide Us with proof of the child's incapacity and dependency within 120 days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the 2 year period following the child's attainment of the limiting age.

To request special enrollment or obtain more information, contact your Benefits Administrator or Paramount Dental member services.

# Enrollment Periods

**Initial Enrollment**
At the time You enroll, You are given a coverage Effective Date. Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. You must notify Your employer if You have a change of marital status or other Qualifying Event relating to You or Your dependents within thirty (30) days from the time the Qualifying Event occurs. Otherwise, changes may be made only at Open Enrollment or Plan renewal.

**Open Enrollment**
Open Enrollment is designated by the Employer and is usually the thirty (30) day period immediately preceding the renewal date of Your Employer's policy with Paramount Dental. During this period, You may drop Your coverage or change dependent coverage. Any changes will be effective on the renewal date of Your Paramount Dental Plan.

**Special Enrollment**
Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. A special enrollment period can occur if an Eligible Employee or Dependent(s) loses coverage under another health plan. A special enrollment period may also begin when Dependent (s) become newly eligible due to marriage, birth, court order, adoption or placement of a child in the home of the Eligible Employee.

The Eligible Employee must request enrollment within 30 days of the Qualifying Event date. During the Special Enrollment Period, the Employee may enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also enroll any newly eligible Dependent(s) of the Employee under the Plan.

## Web Services

Paramount Dental offers information and various services on its website. The website is continually revised, improved and enhanced for Your convenience. Members may:

- Find a Network Dentist,
- Verify benefit plan, renewal dates, dependent coverage, Claim status,
- Print Member Cards,
- Review benefit history,
- Download brochures and Certificates, and
- Acquire oral health and wellness tips.

Online materials serve as the primary source of information for groups, Members, dentists and advisers. Any printed documents that you may have is based on information at a certain point in time and may not be inclusive of all benefits, restrictions and limitations. All documents may also be requested by contacting our Customer Service Center at: 1-800-727-1444.

## Member ID Card

A Paramount Dental Member ID Card will be issued to you upon enrollment.

## Selecting a Dentist – Receiving Dental Care

Dentistry is a highly personal service. You may have any dental treatment performed as decided by You and Your dentist. Your Dental Plan does not dictate what treatment You receive. Only You and Your dentist can determine that. However, Your Plan does determine what services are covered and by what type of dentist (In-Network vs. Out-of-Network). The coverage selected by Your Employer pays for only those Covered Services under Your Paramount Dental Plan listed in this certificate and Summary of Dental Benefits within the Limitations and restrictions presented. You must personally pay for any service which is not covered or for any service that is covered but is subject to Limitations and restrictions. Your Claim will only be processed after completion of the dental service. If You are not sure whether a particular dental treatment is covered or how much You will be required to pay, You may request a Pre-Treatment Estimate from Your dentist. It is a free service offered by Paramount Dental and highly encouraged so you are never surprised about your dental coverage.

Some services are limited by the age of the patient, by how often the service may be performed, or by specific teeth. All time intervals (frequency limitations) required by coverage are independent of calendar year or plan year. Frequency limitations regarding how often services may be performed are continuous. Change of dental plan coverage, termination and reinstatement of coverage does not eliminate the frequency limitations.

Paramount Dental also offers a large, nationwide, network of credentialed dentists to accommodate oral health needs of You and Your family. Simply visit the Find a Dentist link on InsuringSmiles.com, to view a complete listing of general and specialty Network Dentists in Your geographical area. The Network listing generated from the website includes access to all Paramount Dental and leased Networks included in your Plan offered by your Employer that is outlined your Summary of Dental Benefits. Network Dentists provide the same excellent service at a contracted fee, resulting in savings for You and Your family.

You should always verify the plan and your Summary of Dental Plan Benefits selected by Your Employer prior to Your dental visit as it makes a difference in Your coinsurance and savings. Network Dentists are independent contractors and are not Paramount Dental employees.

## Benefit Categories – What is Covered by My Plan?

**Important** - It is very important to understand that your employer will select which plan services are included in your plan. Please review both this Certificate and the Summary of

Dental Plan Benefits carefully. **ONLY the dental services listed in your Summary of Dental Plan Benefits will be covered by your plan.** The Summary of Dental Plan Benefits is part of this Certificate and supersedes any provision of this Certificate. Covered services are also subject to exclusions and limitations and are included in a later section of this certificate.

The various dental services provided by a dentist are classified into the following categories:

1. Diagnostic and Preventative
2. Restorative
3. Endodontic
4. Periodontics
5. Prosthodontics (removable and fixed)
6. Oral Surgery
7. Orthodontics
8. Adjunctive

### Diagnostic and Preventive Services

These services are important to your overall oral health and the detection and prevention of dental disease. They include examinations and evaluations (routine and problem focused), prophylaxes (routine teeth cleanings), radiographs (x-rays), fluoride treatments, and sealants and space maintainers (for children).

### Restorative Services

- Minor Restorative Services – these procedures rebuild and repair your teeth damaged by disease, decay, fracture or injury. Both amalgam (silver) and composite (white tooth colored) fillings on baby and adult teeth and anterior and posterior teeth are considered in this category.
- Major Restorative Services – these services include crowns and crown related services. Crowns may be covering a natural tooth or an implant.

### Endodontic Services

These procedures treat teeth with diseased or damaged nerves. Root canals are included in this category.

### Periodontic Services

- **Non-surgical Periodontics Services** – these procedures involve the treatment of diseases of the gums and supporting structures of the teeth. Nonsurgical procedures include periodontal scaling and root planning, full mouth debridement and periodontal maintenance following a periodontal therapy (periodontal cleanings).
- Surgical Periodontal Services – procedures that related to surgery of your gums which can include osseous surgery and gingivectomy.

### Prosthodontic Services (fixed and removable)

- Bridges, partial and complete dentures are in this category.
- Relines and Repairs – these procedures reline and repair existing dentures (partial and complete) and repair existing bridges.
- Implant Services – the placement of an endosteal implant and the associated abutment.

### Oral Surgery

- Simple Extractions – this procedure is an extraction of a tooth that is erupted or exposed root.
- Surgical extractions of tooth/teeth are included in this category and include the removal of impacted teeth and other extractions including removal of bone. An incisional biopsy of oral tissue for the detection of cancer or other suspected disease is also included in oral surgery services.

### Adjunctive/Other Services

Your Summary of Dental Plan Benefits will list any other benefits that may have been selected.

### Orthodontic Services

A “Rider” to your Plan must be selected and included in your Summary of Dental Plan Benefits to have Orthodontic Services covered. Orthodontic covers traditional braces, clear orthodontic treatment (Invisalign) and removable appliances. Retainers are considered part of the orthodontic treatment.

### How Payment is Made for These Benefits Categories

When filing claims, your dental office will use the appropriate dental code(s) found in the American Dental Association’s current CDT Code Book. The codes are too numerous to list, however the staff at your dental office is well versed in using these codes and the staff can explain them more thoroughly at your request.

It is best, though not necessary, to have your dentist file a pretreatment estimate for services totaling over $300 to fully identify what benefits are available to you. This will avoid any confusion as to the balance you may owe your dentist. Not all plans cover the same procedures, and if there is any doubt to the coverage of your plan a representative of Paramount Dental would be glad to go over it with you. Your dentist also has access to your specific coverage and can review it with you.

## Coinsurance

Covered Services and the percentage of covered expense provided by the Plan and limitations to covered services are indicated on Summary of Dental Plan Benefits. The percentage of plan payment (coinsurance) is valid only for services obtained from participating network Dentists contracted with Paramount Dental or a leased network. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as

"balance billing" and is not enforceable for Out-of-network Dentists as they are under no obligation to limit their fees.

# Plan Features

This list of plan features describes the features that are available through Paramount Dental but may not be included in the coverage that you or your employer has selected. To see a list of plan features that are specific to your benefit coverage, please refer directly to Summary of Dental Plan Benefits. If a plan feature is not listed on your Summary of Dental Plan Benefits then it is not a part of your Dental Benefit Plan.

### Plan Annual Maximum Benefits/Plan Year

Benefits payable under the Plan, regardless of whether coverage is continuous or not, shall be subject to the Plan Annual Maximum for each plan year. Payments under your Certificate for ALL Covered Services apply to the Plan Annual Maximum benefit excluding orthodontic services. Change of the dental plan coverage, termination, and reinstatement of coverage does not eliminate frequency limitations or Plan Annual Maximum benefit used.

Annual maximum benefits are based on a policy/benefit year unless otherwise noted on the Summary of Dental Plan Benefits beginning with the Plan's effective date of coverage,

After the Plan Annual Maximum Benefit is exhausted, you are responsible for all subsequent charges to your dentist.

### Lifetime Maximum Benefit – Orthodontics

If your plan includes orthodontics coverage, your Summary of Dental Benefits will list a lifetime maximum of orthodontic benefits per member. This is the cumulative dollar amount that will be paid for orthodontic dental care for the life of the Member.

### Deductible

The Plan Year Deductible (if any) is applicable to Covered Services incurred in each Plan Year. Your policy will determine the Deductible application method chosen by Your employer. The available methods include:

### Out of Pocket Deductible-

An out of pocket deductible is the specified & consistent amount reduced from the plan's covered expense which must be paid in full by the Member each plan year. It is applied chronologically according to the dates in which the Covered Services were completed and increases the patient responsibility by the specified amount until the earlier of two events 1) individual deductible is met, or 2) family deductible is satisfied.

Ex: (Fee Allowed X Co-Insurance) – Deductible = Plan Payment

Patient A receives major services covered at 50% under the plan. This patient is responsible for a $50 individual deductible.

### Benefit Deductible

A benefit deductible is the amount a Member must pay toward Covered Services before the carrier will reimburse for those Covered Services. This amount may vary based upon the co-insurance of the Covered Service.

Ex: (Fee Allowed – Deductible) X Co-Insurance = Plan Payment
Patient B receives major services covered at 50% under the plan. This patient is responsible for a $25 individual deductible.

### Waiting Period

The Waiting Period is the period of time beginning on the Member's Effective Date before benefits for certain Covered Service become eligible for reimbursement. Unless otherwise specified, the most recent effective date is utilized in the application of the Waiting Period, this includes a change to Your dental plan coverage such as termination and reinstatement of coverage.

### Alternate Benefits

There is often more than one service that can be used to appropriately treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. If applicable, the amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. A Member and his Dentist may decide on a more costly service or material than We have determined to be satisfactory for the treatment of the condition. In this case, the Plan will be a benefit toward the cost of the more expensive service or material, but the payment will be limited to the benefits payable for Covered Expenses for the least costly Covered Service.

### Unbundling

When charges for less complicated Services performed in conjunction with the more comprehensive/extensive definitive treatment are separated, these less complicated components may be considered as parts of the primary Service. If the Dentist bills separately for the primary Service and each of its component parts, the total benefit payable for all related charges will be limited to the benefits payable for Covered Expenses for the primary Service.

# Service Exclusions

Paramount Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Benefits. All charges for the same will be your responsibility (though your payment obligation may be

satisfied by insurance or some other arrangement for which you are eligible):

**General Exclusions**
All Master Group Policies and Certificates issued or administered by Paramount Dental are subject to the following General Exclusions.

This plan will not pay for:

1. Dental services that are not listed in the Plan Covered Services and Plan General Exclusions, Limitations and Restrictions attached to this Certificate.
2. Claims for dental services rendered before the Effective Date or after coverage is terminated.
3. Claims for dental services covered under non-dental insurance.
4. Claims for services performed primarily to rebuild occlusion or for full mouth reconstruction.
5. Claims for Enrollees until Paramount Dental receives the appropriate contracted payment(s) for Premiums.
6. Claims for services which are not completed.
7. For duplicates, lost, or stolen prostheses, appliances, and/or radiographic images.
8. A Claim must be received within one year from the date of service.
9. Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous (baby) teeth.
10. Orthodontic treatment, unless otherwise specified in your Summary of Dental Plan Benefits.
11. Treatment of temporomandibular joint or jaw joint disorder (TMJ).
12. Dental services provided by a non-network participating dentist to the extent that the charges exceed the amount payable for services under the nonparticipating dentist fee schedule.
13. Pediatric dental Essential Health Benefits (EHB) as mandated by the Affordable Care Act (ACA).
14. Dental services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
15. Dental services or charges separately billed by hospitals, laboratories, pharmacies or other institutions other than a dentist practice.
16. Experimental or investigational dental treatment.
17. Dental services as a result of your participation in a misdemeanor, felony, riot or insurrection.
18. Dental services charged and filed on a claim under an unspecified CDT service code X999.
19. Submitted claims for which Paramount Dental has not received the dentist documentation (federal W9 form, documentation requirements – radiographs, primary explanation of benefits, etc., or unable to process due to incorrect filing information) required to determine and finalize the claim benefit.

# Service Limitations

The benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Paramount Dental plan or, at the request of your group, any dental plan:

Diagnostic Evaluations and Treatments
Evaluations (examinations), including any and all procedure codes, are payable as stated in your Summary of Benefits. These include all examinations and evaluations performed by any general dentist or specialist.

A comprehensive oral evaluation or a comprehensive periodontal evaluation for a new or established patient is payable according to the time period specified in your Summary of Benefits. A comprehensive periodontal evaluation will only be payable for members that are age 14 and above.

Diagnostic Imaging, Tests, and Examinations
The maximum amount considered for all radiographic images (also referred to as X-rays) taken on one day will be equivalent to an allowance of a full mouth X-ray. The difference may not be billed to the Enrollee.

Panoramic (including image capture only) or full mouth X-rays are payable according to your Summary of Benefits. If a full mouth X-ray is performed within 12 months of any bitewing image(s), the allowable amount for the full mouth X-ray will be reduced by the charges for bitewing(s). Panoramic or full mouth X-rays will not be payable if performed within 12 months of a set of vertical bitewings images.

Periapical images (including image capture only) are payable up to a maximum of 3 during a 12-month period.

Occlusal images (including image capture only) are payable only once per arch per 12 months.

Vertical bitewings (including image capture only) are payable once per 12 months unless a complete series of images or four bitewings were paid in that same 12 months.

Bitewing radiographic images (including image capture only) are limited to the amount specified in your Summary of Benefits. Bitewings will not be payable if performed within 12 months of a complete series of images or a set of vertical bitewings images.

2D cephalometric images or 2D oral/facial photographic images (including image capture only) will be payable only if performed in conjunction with a Plan that covers orthodontic services and treatment. Cephalometric images are payable

every 2 years unless image captures only were paid during the same 2 years. 2D oral/facial images are payable every 5 years unless image captures only were paid during the same 5 years.

Pulp vitality tests are payable for one charge per date of service.

Diagnostic casts are payable once per 5 years and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Preventive Services:
Prophylaxis: A teeth cleaning (includes prophylaxis, periodontal scalings and root planning, periodontal full mouth debridement and periodontal maintenance) is payable according to the limitations listed in your Summary of Benefits., regardless of the dentist's specialty. A teeth cleaning for children under the age of 14 will be payable when filed as a child's cleaning.

Fluoride: A preventive fluoride treatment is payable as listed in your Summary of Benefits.

Sealants: Will be payable on permanent molar teeth (per tooth) as listed in your Summary of Benefits. A replacement for a sealant will not be payable for a period of 5 years. If a sealant was applied to a tooth, a restoration on the same tooth will not be payable for a period of 3 years.

Space Maintenance: Space maintainers are payable once every 3 years for children under 13 years of age The re-cementation or re-bonding of a space maintainer is payable only after 12 months after the initial placement and only once per 12 months.

Restorative Services:
A restoration/filling (amalgam or resin-based composite) is payable as listed in your Summary of Benefits. An additional restoration on the same tooth surface will not be payable for a 2-year period. A restoration will not be payable within 2 years of placing a crown on the same tooth or a sealant on the same surface within 2 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered for payment.

Crowns, or Inlays/Onlays (in any combination including implant supported) are payable as listed in your Summary of Benefits. A charge for a crown or an inlay/onlay on a tooth following the placement of an amalgam or resin-based composite restoration on the same tooth is not eligible for payment for a period of 2- years. Crowns, other than prefabricated steel crowns, are not payable for primary teeth. Composite/resin inlays must be laboratory processed.

A resin-based composite (indirect) crown is payable on anterior teeth only.

Individual crowns over implants are payable as listed in your Summary of Benefits.

Not all crowns or inlay/onlays procedure codes are considered covered if a corresponding procedure code using new and advanced materials is determined to be available.

Crowns, inlays/onlays may be subject to review for extensive loss of tooth structure due to caries (decay) or fracture to determine coverage. A pre-treatment estimate is recommended to determine coverage.

A recementation of an inlay, onlay, or crown is payable only once per 12 months and will not be considered for payment if within 12 months of the original cementation.

A protective restoration is payable once every 2 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for a subsequent definitive treatment are subject to an adjustment if performed within 12 months of a protective restoration.

A core buildup will not be payable if performed as specified in your Summary of Benefits. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed. A pre-treatment estimate is recommended to determine coverage.

A pin retention is payable per tooth and limited to posterior teeth only. Additional pins will be disallowed.

A post and core in addition to a crown is payable once per 5 years per tooth. A payment is not eligible if performed within 5 years of a core buildup or another post and core. Procedure is not payable without history of root canal therapy.

Endodontics:
A therapeutic pulpotomy is payable for primary teeth only and only once per tooth per lifetime. Charges are exclusive of the final restoration charge.

All pulpal and endodontic therapy and apexification/recalcification should be coded by the tooth receiving treatment, not the number of canals per tooth. A single periapical will be considered for payment with an endodontic therapy or an apexification/recalcification only (not pulpal). Separate fees for other radiographs and images are considered part of the treatment plan and will be

disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.

Pulpal therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Endodontic therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Apexification/recalcification is limited to children under 16 years of age and once per lifetime. Not eligible for payment for retreatment within 4 years of the date of the original treatment.

An apicoectomy is payable only once per lifetime.

A canal preparation and fitting of preformed dowel or post is payable once per 7 years. Charges will be disallowed if submitted in conjunction with a post and core, fabricated post, or prefabricated post/core.

Non-Surgical and Other Periodontal Services:
Periodontal maintenance is payable as listed in your Summary of Benefits. This procedure will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a scaling in the presence of gingival inflammation, or a full mouth debridement.

A scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable as listed in your Summary of Benefits. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling in the presence of gingival inflammation, a full mouth debridement or periodontal maintenance. The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Not payable on deciduous teeth. This procedure requires the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. Charges not meeting established criteria will be disallowed. A pretreatment estimate is recommended to determine coverage. Dental Review Team maintains discretionary authority regarding review requirements.

A scaling in presence of generalized moderate or severe gingival inflammation – full mouth is payable once every 5 years and only for enrollees over 15 years of age. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a full mouth debridement or periodontal maintenance.

A full mouth debridement is payable only for enrollees over 15 years of age. Procedure is payable once every 3 years and 3 years must lapse between any associated periodontal scalings (scaling and root planning and scaling in the presence of gingival inflammation) were performed. Will not be payable if performed within 6 months of or the same date of service as a prophylaxis, a scaling and root planning or a scaling in the presence of gingival inflammation, or periodontal maintenance.

Periodontic Surgical
The following services are payable only once per area treated within a 5-year period:

- Gingivectomy or gingivoplasty (four or more teeth/tooth per quadrant only)
- Clinical crown lengthening (per tooth)
- Osseous surgery
- Guided tissue regeneration (includes barrier and its removal, as necessary)

Two tissue grafts (of any type, including pedicle soft, autogenous connective, non-autogenous connective, and free soft) are payable once per area treated/quadrant every 5 years. Teeth #24-25 are considered one site.

Prosthodontics:
One upper and one lower denture (including complete, immediate, partial, immediate partial, overdenture and interim) are payable as listed in your Summary of Benefits. Charges for a conventional, removable partial dentures or a complete denture are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch or of any repairs, relines, rebases. Separate charges for diagnostic casts will be disallowed. An immediate denture will not be payable if used to replace a complete denture.

A repair to a complete or partial denture is payable once per 6 months only after 6 months has elapsed since the initial date of delivery of the appliance. A repair to a partial denture that replaces all teeth and acrylic on framework is payable once per 4 years only after 4 years has elapsed since the initial delivery of the appliance

A rebase or reline to a complete or partial denture is payable once per 4 years only after 6 months has elapsed since the initial date of deliver of the appliance.

Two tissue conditioning charges will be payable only within 6 months of delivery of immediate partial/denture only.

Fixed partial dentures, including partial denture pontics (non-resin), partial denture retainers (cast metal and porcelain/ceramic retainers only), and partial denture retainers-crowns (non-resin) are payable as listed in your Summary of Benefits. Charges are subject to the same definitions and restrictions as single restoration crowns. Each unit of a fixed partial denture must be

identified on the claim. Not eligible for pontics to replace third molars. All fixed prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 5 years of the original placement.

A re-cement or re-bond of a fixed partial denture is payable only once per 12 months per fixed partial denture and only after 12 months of the original cementation.

Oral Surgery:
Surgical extraction of an erupted tooth requiring removal on bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated, and the removal of residual tooth roots procedures include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed.

An exposure of an unerupted tooth or the placement of a device to facilitate the eruption of an impacted tooth will be payable only once per lifetime if the procedure is performed in conjunction with a Plan orthodontic covered services and treatment.

An incisional biopsy of soft oral tissue will be disallowed if performed in conjunction with an apicoectomy.

A transseptal fiberotomy/supra crestal fiberotomy is payable only on anterior permanent teeth and bicuspids and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Alveoplasty in conjunction with routine extractions are subject to review. Charges not meeting generally accepted standards of care will be disallowed.

Vestibuloplasty, ridge extension, procedures charges in conjunction with implant services will be disallowed.

Removal of torus mandibularis is payable only once per arch per lifetime.

Incision and drainage of abscess filed in conjunction with definitive treatment will be disallowed.

A frenectomy is payable once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed.

Excision of pericoronal gingiva filed in conjunction with definitive restorative treatment will be disallowed.

Implant Services
A surgical placement of an implant body (endosteal) or a mini implant is payable as listed in your Summary of Benefits. Allowance includes the treatment plan, local anesthetic and post-surgical care. Coverage is limited to enrollees over 15 years of age.

A prefabricated abutment or a custom fabricated abutment is payable once per 5 years per tooth site. Coverage is limited to enrollees over 15 years of age.

Single crowns and fixed partial denture retainers (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported single crowns and fixed partial dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Removable dentures and fixed dentures (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported removable dentures and fixed dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Adjunctive/Other Services Limitations
Palliative (emergency) treatments will be payable 2 per 12-month period. Charges filed in conjunction with definitive treatment will be disallowed.

Deep sedation/general anesthesia and intravenous moderate (conscious) sedation/analgesia will be payable up to a total of 30 minutes per date of service.

Inhalation of nitrous oxide/analgesia will be payable once per date of service.

An athletic mouth guard is payable once per 12 months.

Occlusal guards are payable once every 5 years. Charges to modify the appliance or for occlusal adjustment are not payable.

Teledentistry benefits are payable as specified in your Summary of Benefits.

# Disallowed Services

Participating Dentists may not charge eligible persons for disallowed services or supplies. All charges fromnon-participating dentists for the disallowed services areyour responsibility.

# How Payment Is Made

**In-Network Dentists**
In-Network Dentists are responsible for submitting claims to Paramount Dental on Your behalf for rendered services. Paramount Dental will reimburse the In-Network Dentist directly for Covered Services.

A Member is responsible for the Deductible and any out-of-pocket expenses required by the Plan including the co-insurance and the cost of services that are not covered by the Plan. It is possible that Your dentist's charges for one or more of the services may be higher than the maximum allowable under Your Paramount Dental. If so, an In-Network Dentist must reduce the charged amounts. If a Member is billed by an In-Network Dentist for a Covered Service (other than the Deductible, co- insurance, or amount above the maximum allowable fee), the Member should contact either the In-Network Dentist or Paramount Dental.

**Out-Of-Network Dentists**
If You visit an Out-Of-Network Dentist, you may be personally responsible for submitting claims directly to Paramount Dental. Some Out-Of-Network Dentist will file the claim as a courtesy to their patients, but they are under no obligation to do so. A Member must provide all of the information the Plan needs to process such claims, including an ADA approved claim form, an invoice of the charges and proof of payment. If a Member does not provide this information, a Member may not be paid or the payment will be distributed to the Out-Of-Network Dentist.

A Member is responsible for the Deductible, any out-of-pocket expenses required by the Plan including the coinsurance and the cost of services that are not covered by the Plan, and any charges above the maximum allowable for the service.

Your out-of-pocket expenses will most likely be higher by seeing an out-of-network dentist because your dentist can Balance Bill the amount that is not covered by Paramount Dental to you and you are responsible for all charges not covered by your Dental Plan.

**Filing a Claim**
Network Dentists are responsible for submitting claims to Paramount Dental on your behalf. Out-Of-Network Dentist may file the claim as a courtesy to their patients, but are under no obligation to do so. All claims should be submitted to the Paramount Dental address provided in a separate section of this document. The following information should be included on a standard ADA claim form:

1. Covered Employee's name, address, and identification number (SSN)
2. Patient's name, date of birth, and identification number (SSN)
3. Itemized bill including the ADA code, description of each charge, and date of service
4. Name and address of the Rendering Dentist
5. Rendering Dentist's Tax ID Number (W-9 Form)

Note: To be considered for payment, a claim must be submitted within 1 year from the date of service. Some services may require additional information, such as a radiograph image or a periodontal chart before being processed. Benefit payment can only be determined at the time that that claim is submitted with all required documentation. Reference the Plan General Exclusions, Limitations, and Restrictions, including provider supporting documentation provision for more information.

# Notice of Claim

We must receive written notice within sixty (60) days after a Claim starts or as soon as reasonably possible. Failure to give notice within that time will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give notice at that time, but such notice was given as soon as was reasonably possible. The notice shall be sent to Paramount Dental or given to Our agent. Notice given by or on behalf of the Member or the Member's beneficiary to Us or to any of our authorized agents with information sufficient to identify the Member is considered notice to Us. If You visit an Out-of-Network Dentist, You may personally be responsible for submitting Claims directly to Paramount Dental.

# Claim Forms

Your dentist will file Your claim or provide You with the forms necessary to file the claim. If Your dentist does not provide these forms within fifteen (15) days, You may send Us a written statement to satisfy this requirement. This statement should include enough information to identify You as well as the nature and extent of the Claim. It should be sent to Us within the time stated in the Proof of Loss provision.

Once Paramount Dental processes Your dental Claim, You will receive an Explanation of Benefits explaining payment amounts. It is possible that Your dentist's charges for one or more of the procedures may be higher than the maximum allowed under Your Paramount Dental. If so, a contracted Network Dentist must reduce the charged amounts. An Out-of-Network Dentist may charge You for the difference since they are not contractually liable to accept Your plan's fee schedule.

# Proof of Loss

We must receive written proof of loss within ninety (90) days of a Claim. If it is not possible for proof to be provided within

the ninety (90) days, We will not deny a Claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless You are legally incapacitated.

## Time of Payment of Claims

Benefits for loss covered by the Policy will be paid when Paramount Dental receives all information necessary, including premium payment, to correctly adjudicate the claim, but not more than thirty (30) days after receipt of all necessary information. Upon the Member's death, any payments outstanding will be paid, at our option, to the Member's beneficiary or to the Member's estate.

If We fail to pay or deny a clean claim in the time required, and We subsequently pay the claim, We will pay the provider that submitted the claim interest on the allowable amount of the claim.

## Legal Actions

A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

## Coordination of Benefits

Coordination of Benefits ("COB") applies to this plan when an eligible person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this plan's benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

**Terms:**

1. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    a. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

    b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, which is associated with a Covered Service for which reimbursement is available or for which reimbursement would be available but for the application of contractual limitations. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

4. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the plan year excluding any temporary visitation.

5. Benefit reserve is the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

**Order of Benefit Determination Rules:**

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
3. Each Plan determines its order of benefits using the first of the following rules that apply:

a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the [calendar] year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(2) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(3) For a Dependent Child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

f. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

### Effect on the Benefits of this Plan:
When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

### Right To Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Paramount Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Paramount Dental need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Paramount Dental any facts it needs to apply those rules and determine benefits payable.

### Facility of Payment
Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan or plans, Paramount Dental will have the right, exercisable alone and at its discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision. The amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments; Paramount Dental will be fully discharged from liability under the Plan. The benefits that are payable in accordance with this provision will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this provision.

## Right of Recovery
Whenever payments have been made in excess of the amount due under the Plan, the Paramount Dental shall have the right, exercisable alone and in its sole discretion, to recover such excess payments from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

## Termination of Coverage

Your dental coverage may be automatically terminated:
When Your employer advises Paramount Dental to terminate Your coverage;

When Your employer fails to pay timely Premium payments or fees to Paramount Dental; or

For any other reason stated in the Policy.

A person whose Eligibility is terminated may not continue coverage under their Employer's contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) or comparable, nonpreempted state law.

## Continuation of Coverage

Continuation Coverage Rights Under The Consolidated Omnibus Budget Reconciliation Act Of 1985 (COBRA)

### Introduction
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to an Enrolled Employee who would otherwise lose coverage under the Plan. It can also become available to Enrolled Dependents covered under the Plan when they would lose their coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the COBRA Procedures or contact the Plan Administrator. In the event that an individual receives a COBRA election form with incorrect plan information, the Plan will notify the individual of the accurate Plan terms. The election will be in accordance with the accurate Plan benefit, terms, and coverage.

### What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage will be offered to

each person who is a “Qualified Beneficiary.” The Enrolled Employee and each Enrolled Dependent could become Qualified Beneficiaries if coverage under the Certificate is lost because of the Qualifying Event. Under the Master Group Policy, Qualified Beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

An Enrolled Employee will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of either the following:

- Hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct by the Enrolled Employee.

An Enrolled Spouse will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of the following:

- The Enrolled Employee dies;
- The Enrolled Employee’s hours of employment are reduced;
- The Enrolled Employee’s employment ends for any reason other than his/her gross misconduct;
- The Enrolled Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The Enrolled Employee becomes divorced or legally separated from his/her Enrolled Spouse

An Enrolled Child will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of any of the following:

- The Enrolled Employee dies;
- The Enrolled Employee’s hours of employment are reduced;
- Employment of the Enrolled Employee ends for any reason other than his/her gross misconduct;
- The Enrolled Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The Enrolled Employee becomes divorced or legally separated from his/her spouse; or
- The Enrolled Child is no longer eligible for coverage under the Plan as a “Dependent Child.”

### When is COBRA Coverage Available?

The Master Group Policy will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

Enrolled Employee or Dependent must notify the Plan Administrator within 60 days after the Qualifying Event occurs.

### How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children who are Qualified Beneficiaries.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Enrolled Employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the divorce or legal separation of the Enrolled Employee, or an Enrolled Dependent losing eligibility for coverage under the Certificate as a Dependent Child, COBRA continuation coverage lasts up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Enrolled Employee’s hours of employment, and the Enrolled 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. 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.

Disability extension of 18-month period of continuation coverage. If an Enrolled Person covered under Your Certificate is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, each Enrolled Person may be entitled to receive up to an additional 11 months of COBRA continuation coverage (while the disability continues), for a total maximum of 29 months.

Second Qualifying Event extension of 18-month period of continuation coverage
If an Enrolled Person experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the Enrolled Spouse and Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator.

Questions concerning Your Certificate, the Master Group Policy or Your COBRA continuation coverage rights should be addressed to Your Plan Administrator or contacts identified below. 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) in Your area (EBSA Regional Office: Cincinnati Regional Office, 1885 Dixie Highway, Ste 210, Ft. Wright, KY 41011-2664, Tel 859.578.4680/Fax 859.578.4688) or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Change In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members.

## Questions and Assistance

Questions regarding your policy or coverage should be directed to:
Claims Department Paramount Dental.
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

## General Conditions and Additional Information

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan. No failure to enforce any provision of the Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

## Entire Contract & Changes

The Policy, including the endorsements, Certificates, Summary of Dental Plan Benefits, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy will be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by You or the Employer, in the absence of fraud, as a representation and not a warranty.

We may amend coverage, limitations to the Covered Services, General Exclusions, Annual Maximum, benefit payments or any other terms of this Certificate or the Master Group Policy upon thirty (30) days written notice to You and Your employer. This Certificate will pay for any Covered Services rendered prior to the Effective Date of the change. If there are any discrepancies as to coverage, limitations to Covered Services, General Exclusions, Annual Maximum or other provisions stated herein and as stated in the Master Group Policy, the provisions of the Master Group Policy will supersede those set forth herein.

## Claims Appeal Procedure

Informal Claims Appeal Procedure
Your Paramount Dental plan has been carefully designed to provide You with the maximum amount of covered benefits for Your level of payment/Premium. Since Paramount Dental is always looking for ways to make Our Master Group Policies and Certificates even better, Your suggestions are encouraged. Occasionally, even after You have reviewed the applicable sections of this Certificate pertaining to Your issue at hand, You may have a question. Your questions may involve dentists, Covered Services, the agents who sold and serviced Your Paramount Dental plan, policies, or procedures.

Paramount Dental always notifies You or Your authorized representative of a benefit determination after Your Claim is filed. This notice is made via an Explanation of Benefits (EOB). An adverse benefit determination is any denial, reduction or termination of the benefit for which You filed a Claim, or a failure to provide or to make payment (in whole or in part) of the benefit You sought. This includes a determination based on Eligibility, the administration of Covered Services, Limitations or restrictions, and payment amounts. If You receive notice of an adverse benefit determination, and if You think that Paramount Dental incorrectly denied all or part of Your Claim, You may take the following steps:

First, You or Your dentist should contact Paramount Dental's Member Services team and ask them to check the Claim to make sure it was correctly processed. If You contact Us in writing, please enclose a copy of Your Explanation of Benefits and describe the problem. Paramount Dental provides this opportunity for You to describe problems and submit information that might indicate that Your Claim was improperly denied and allow Paramount Dental to correct this error quickly.

Formal Claims Appeal Procedure
Whether or not You have contacted Paramount Dental informally, as described above, to recheck the initial determination of Your Claim, You or Your authorized representative may submit Your Claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of Your Claim, You must send Your request in writing to the Dental Claims Review Team at Paramount Dental.

You must include Your name and address, the Member's ID number, the reason You believe Your Claim was wrongly denied, and any other information You believe supports Your Claim, including sections of Certificate that support Your appeal. If You would like a record of Your request and proof that is was received by Paramount Dental, You should mail it certified mail, return receipt requested. You or Your authorized representative should seek a review as soon as possible after You receive Your EOB; however, You must file Your appeal within ninety (90) days of the date of which You receive Your notice of the adverse benefit determination You are asking Paramount Dental to review.

The Dental Claims Review Team will make their decision and notify You in writing within 30 days of receiving Your request. Their notice of any adverse determination will: (a) inform You of the specific reasons for the denial; (b) list the pertinent Master Group Policy/Certificate provision on which the denial is based; (c) contain a statement that You are entitled to receive upon request and at no cost, reasonable access to and copies of the documents, records and other information relevant to the decision to deny Your Claim; and (d) contain a statement that You may seek to have Your Claim re-evaluated by the appropriate Department of Insurance in Your state of domicile. You may also have the right to seek to have Your Claim paid by filing a civil action in court.

# Notice of Privacy Practices

In compliance with certain applicable laws, the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Paramount Dental has adopted these policies. Paramount Dental acknowledges participants' privacy rights as specified in these laws, and has adopted policies and procedures to ensure Your privacy rights are protected.

This Notice describes how nonpublic personal financial information (NPFI) and protected health information (PHI) about You may be used and disclosed and how You can access this information. In this Notice, We explain how We protect the privacy of Your NPFI and PHI, and how We will allow it to be used and given out (disclosed). We are required to provide You with a copy of this Notice of privacy practices upon request. We must follow the privacy practices described in this Notice while it is in effect.

Our Commitment Regarding Your Confidential Information:
We understand the importance of Your NPFI and PHI (hereafter known as Confidential Information), and follow strict policies (in accordance with state and federal privacy laws) to keep Your information private.

Our Privacy Principles:

- We do not sell customer Confidential Information.
- We do not provide customer Confidential Information to persons or organizations outside Paramount Dental and Our business associates for marketing purposes.
- We contractually require any person or organization providing products or services on Our behalf to protect the confidentiality of information We obtain from You.

We afford prospective and former customers the same protections as existing customers with the respect to the use of Confidential Information. Your privacy is a high priority for Us and it is treated with the highest degree of respect. We collect and use Confidential Information We believe is necessary to administer Our business and to provide You with customer service. We use Confidential Information to underwrite Your policies, process Your Claims, ensure proper billing, and service Your accounts. We share Confidential Information as necessary to handle Your Claims and to protect You against fraud and unauthorized transactions. However, We want to emphasize that We are committed to maintaining the privacy of this information in accordance with law. All individuals with access to Confidential Information about Our customers are required to follow this policy.

Confidential Information Collected:

- Confidential Information includes demographic data that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health, the provision of health care to You, or the payment for that care.
- Confidential Information includes Your name, address, date of birth, marital status, sex, social security number, dental information, and Enrollee information, including information about Your transactions with Us, such as Claim history and Premium payments.
- Information Disclosed:
- We may provide Confidential Information to You in order to supply You with information about Your Benefits, or if You request to inspect Your Confidential Information.
- We may provide Your Confidential Information to health care providers and to Our business associates who request Confidential Information for payment-related activities and for health care operations.
- We may provide Your Confidential Information to someone who has the legal right to act on Your behalf.
- We may provide Confidential Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.
- We may provide Confidential Information without Your written permission for matters in the public interest such as public health and safety activities or averting a serious threat to the health or safety of others.
- We may provide Confidential Information that We collect to third-parties involved in the underwriting, processing, servicing and marketing of Your Paramount Dental insurance products. We will not provide this information to any other third party for purposes other than set forth above unless We have a written agreement that requires such third party to protect the confidentiality of this information or Your written authorization.

- The law or the courts may require Us to provide Confidential Information to persons or agencies involved in regulatory, enforcement, or civil or criminal judicial activities.
- When We provide Your Confidential Information to any third party, We will provide only a limited data set, or if needed, the minimal amount of information that We deem is necessary.
- We do not disclose any Confidential Information about Our customers to anyone except as permitted or required by law.
- We must obtain Your written authorization for any disclosures of Your Confidential Information for purposes other than those listed above, including disclosures of psychotherapy notes or for marketing purposes.
- We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.

Security of Your Confidential Information:

- Access of Your Confidential Information is available from Us only to persons involved in underwriting, processing information, marketing company products, or providing dental care for Your benefit. Access must be granted to those entities to enable them to provide the excellent service You have come to expect from Paramount Dental.
- We maintain physical, electronic, and procedural safeguards that comply with state and federal standards to guard Your Confidential Information.
- If We become aware that an item of Confidential Information may be materially inaccurate, We will make a reasonable effort to confirm its accuracy and correct any error as appropriate.
- If We believe Your Confidential Information has been breached, You will receive a written notification of the suspected breach.

Individual Rights:

- You have a right to learn about the nature and substance of any Confidential Information Paramount Dental has in its files about You. We reserve the right to charge a reasonable cost-based fee for copying and postage.
- You have the right to an accounting of certain disclosures of Your Confidential Information.
- You have the right to request that We place restrictions on the way We use and disclose Your Confidential Information. We will inform You within thirty (30) days of Our decision concerning Your request. We will agree to any request to restrict the disclosure of Your Confidential Information if the disclosure is for carrying out payment or health care operations and You have paid the provider in full out of Your pocket.
- You have a right to inspect Your Confidential Information and request that We amend it in Our files.
- You have a right to obtain a copy of Your Confidential Information that We use or maintain in an electronic health record. We reserve the right to charge a reasonable cost-based fee to provide such information to You or Your specific designee.
- Individual Enrollees who believe that the way we communicate decisions related to payment and Benefits may endanger their Confidential Information may request that We communicate with them using a reasonable alternative means or location.

Duties:

- Paramount Dental is required to abide by the terms of this Notice, and reserves the right to change the terms of this Notice at any time, provided that applicable law permits such changes. These revised practices will apply to Your Confidential Information regardless of when it was created or received. Before We make a material change to Our privacy practices, We will provide You with a revised Notice of Privacy Practices.
- Where multiple state or federal laws protect the privacy of Your Confidential Information, We will follow the requirements that provide the greatest privacy protection.

Further information:

If You need more information about Our privacy policy, or are concerned that We may have violated Your privacy rights, please contact Paramount Dental's Privacy Officer.

You may also submit a written complaint to:
Attn: Region
V, Office of Civil Rights
U.S. Dept. of Health and Human Services 233 N.
Michigan Ave, Ste 240
Chicago, IL 60601
Voice mail: 312.866.2359
Fax: 313.866.1807

We support Your right to protect the privacy of Your Confidential Information. We will not take action against You.

## Physical Examinations and Autopsy

We reserve the right, at our own expense, to examine a Member when and as often as may be reasonably required for the determination of a claim. We may request an autopsy in case of death where it is not forbidden by law.

# ERISA

As a participant in a Paramount Dental plan, You may be entitled to certain rights and protections under ERISA. You should check with Your employer to determine whether ERISA applies in Your situation. If You are covered by ERISA, then You may:

- Obtain the Plan Administrator's name, address, and telephone number from Your employer.
- Examine (without charge) at the Plan Administrator's office and at certain other locations, all plan documents, including the group insurance contracts, and copies of all documents filed by the Plan Administrator with the Internal Revenue Service such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- Receive a Summary Annual Report (SAR), Summary Plan Description (SPD) and a Summary of Material Modifications (SMM).
- Receive a written explanation if Your Claim for Benefits has been denied. You have the right to request a review of any such denial. If Your Claim is still denied, You may sue for Your Benefits.
- File suit in Federal court if materials You requested aren't received within thirty (30) days (unless the materials weren't sent because of matters beyond the administrator's control), or if You feel Benefits have been improperly denied, or if You have been discriminated against exercising Your rights under ERISA. If You are successful, the court may require the administrator to provide the materials You requested and pay up to $110 a day until You receive them. The court will decide who should pay the 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 frivolous.

First, consult Paramount Dental or Your employer to be certain You thoroughly understand the dental Benefits coverage and Claims procedures. If, after following all procedures, satisfactory resolution has not been reached, You may wish to contact the appropriate state department of Insurance or the United States Department of Labor for assistance. Your exercise of any rights under ERISA will not adversely affect Your employment status or plan benefits.

# Grace Period

A grace period of thirty-one (31) days will be allowed for the payment of each Premium due after the first Premium. This coverage will remain in effect during the grace period unless the Employer has given advance written notice of discontinuance of coverage.

# Notification to Insureds

Paramount Dental will notify the Employer in writing by mail to the Employer's last known address at least thirty (30) days prior to the Effective Date of the termination of Your insurance, a change in Your Premium, a change in Eligibility or a change in Your Benefits. This notice will also be provided to You, the agent, and the Plan Administrator, if any.

# Misstatement of Age

If the age of any individual covered under the Policy has been misstated, all amounts payable under this policy shall be such as the Premium paid would have purchased at the correct age.

# Incontestability

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

# Conformity with State Statutes

If any provisions of the Plan is contrary to any law to which it is subject, such provision will be amended to conform to the minimum extent necessary to satisfy legal requirements.
**Questions regarding your policy or coverage should be directed to:**

Paramount Dental
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

If You (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: 1-800-622-4461 / (317) 232-239
Complaints can be filed electronically at www.in.gov/idoi.

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D0120 | PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT | 100/100 |
| D0140 | LIMITED ORAL EVALUATION-PROBLEM FOCUSED | 100/100 |
| D0145 | ORAL EVALUATION FOR A PATIENT UNDER 3 YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER | 100/100 |
| D0150 | COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT | 100/100 |
| D0160 | DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT | 100/100 |
| D0170 | RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT NOT POST-OPERATIVE VISIT) | 100/100 |
| D0180 | COMPREHENSIVE PERIODONTAL EVALUATION-NEW OR ESTABLISHED PATIENT | 100/100 |
| D0210 | INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES | 100/100 |
| D0220 | INTRAORAL-PERIAPICAL FIRST RADIOGRAPHIC IMAGE | 100/100 |
| D0230 | INTRAORAL-PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE | 100/100 |
| D0240 | INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE | 100/100 |
| D0270 | BITEWING-SINGLE RADIOGRAPHIC IMAGE | 100/100 |
| D0272 | BITEWINGS-TWO RADIOGRAPHIC IMAGES | 100/100 |
| D0273 | BITEWINGS-THREE RADIOGRAPHIC IMAGES | 100/100 |
| D0274 | BITEWINGS-FOUR RADIOGRAPHIC IMAGES | 100/100 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D0277 | VERTICAL BITEWINGS-7 TO 8 RADIOGRAPHIC IMAGES | 100/100 |
| D0320 | TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION | 100/100 |
| D0321 | OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES BY REPORT | 100/100 |
| D0330 | PANORAMIC RADIOGRAPHIC IMAGE | 100/100 |
| D0340 | 2D CEPHALOMETRIC RADIOGRAPHIC IMAGE ACQUISITION, MEASUREMENT AND ANALYSIS | 100/100 |
| D0350 | 2D ORAL/FACIAL PHOTOGRAPHIC IMAGES OBTAINED INTRAORALLY OR EXTRAORALLY | 100/100 |
| D0460 | PULP VITALITY TESTS | 100/100 |
| D0470 | DIAGNOSTIC CASTS | 100/100 |
| D0701 | PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0702 | 2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0703 | 2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY – IMAGE CAPTURE ONLY | 100/100 |
| D0706 | INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0707 | INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0708 | INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0709 | INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY | 100/100 |
| D1110 | PROPHYLAXIS-ADULT | 100/100 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D1120 | PROPHYLAXIS-CHILD | 100/100 |
| D1206 | TOPICAL APPLICATION OF FLUORIDE VARNISH | 100/100 |
| D1208 | TOPICAL APPLICATION OF FLUORIDE- EXCLUDING VARNISH | 100/100 |
| D1351 | SEALANT-PER TOOTH (PERMANENT MOLAR TEETH) | 100/100 |
| D1510 | SPACE MAINTAINER-FIXED, UNILATERAL - PER QUADRANT | 100/100 |
| D1516 | SPACE MAINTAINER-FIXED-BILATERAL,MAXILLARY | 100/100 |
| D1517 | SPACE MAINTAINER-FIXED-BILATERAL,MANDIBULAR | 100/100 |
| D1520 | SPACE MAINTAINER - REMOVABLE - UNILATERAL - PER QUADRANT | 100/100 |
| D1526 | SPACE MAINTAINER-REMOVABLE-BILATERAL,MAXILLARY | 100/100 |
| D1527 | SPACE MAINTAINER-REMOVABLE-BILATERAL,MANDIBULAR | 100/100 |
| D1551 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY | 100/100 |
| D1552 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR | 100/100 |
| D1553 | RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT | 100/100 |
| D1575 | DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT | 100/100 |
| D2140 | AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT | 50/50 |
| D2150 | AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D2160 | AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT | 50/50 |
| D2161 | AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT | 50/50 |
| D2330 | RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR | 50/50 |
| D2331 | RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR | 50/50 |
| D2332 | RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR | 50/50 |
| D2335 | RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES (ANTERIOR) | 50/50 |
| D2390 | RESIN-BASED COMPOSITE CROWN, ANTERIOR (PRIMARY ONLY) | 50/50 |
| D2391 | RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR | 50/50 |
| D2392 | RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR | 50/50 |
| D2393 | RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR | 50/50 |
| D2394 | RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR | 50/50 |
| D2510 | INLAY - METALLIC - ONE SURFACE | 50/50 |
| D2520 | INLAY-METALLIC-TWO SURFACES | 50/50 |
| D2530 | INLAY-METALLIC-THREE OR MORE SURFACES | 50/50 |
| D2542 | ONLAY-METALLIC-TWO SURFACES | 50/50 |
| D2543 | ONLAY-METALLIC-THREE SURFACES | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D2544 | ONLAY-METALLIC-FOUR OR MORE SURFACES | 50/50 |
| D2610 | INLAY-PORCELAIN/CERAMIC-ONE SURFACE | 50/50 |
| D2620 | INLAY-PORCELAIN/CERAMIC-TWO SURFACES | 50/50 |
| D2630 | INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES | 50/50 |
| D2642 | ONLAY-PORCELAIN/CERAMIC-TWO SURFACES | 50/50 |
| D2643 | ONLAY-PORCELAIN/CERAMIC-THREE SURFACES | 50/50 |
| D2644 | ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES | 50/50 |
| D2650 | INLAY - RESIN-BASED COMPOSITE - ONE SURFACE | 50/50 |
| D2651 | INLAY-RESIN-BASED COMPOSITE-TWO SURFACES | 50/50 |
| D2652 | INLAY-RESIN-BASED COMPOSITE-THREE OR MORE SURFACES | 50/50 |
| D2662 | ONLAY - RESIN-BASED COMPOSITE - TWO SURFACES | 50/50 |
| D2663 | ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES | 50/50 |
| D2664 | ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES | 50/50 |
| D2710 | CROWN-RESIN-BASED COMPOSITE (INDIRECT) | 50/50 |
| D2740 | CROWN-PORCELAIN/CERAMIC SUBSTRATE | 50/50 |
| D2750 | CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D2751 | CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50/50 |
| D2752 | CROWN-PORCELAIN FUSED TO NOBLE METAL | 50/50 |
| D2753 | CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D2780 | CROWN-3/4 CAST HIGH NOBLE METAL | 50/50 |
| D2781 | CROWN-3/4 CAST PREDOMINANTLY BASE METAL | 50/50 |
| D2782 | CROWN-3/4 CAST NOBLE METAL | 50/50 |
| D2783 | CROWN-3/4 PORCELAIN/CERAMIC | 50/50 |
| D2790 | CROWN-FULL CAST HIGH NOBLE METAL | 50/50 |
| D2791 | CROWN-FULL CAST PREDOMINANTLY BASE METAL | 50/50 |
| D2792 | CROWN-FULL CAST NOBLE METAL | 50/50 |
| D2794 | CROWN-TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D2799 | INTERIM CROWN – FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION | 50/50 |
| D2910 | RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION | 50/50 |
| D2915 | RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE | 50/50 |
| D2920 | RE-CEMENT OR RE-BOND CROWN | 50/50 |
| D2930 | PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D2931 | PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH | 50/50 |
| D2933 | PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW (PRIMARY TOOTH) | 50/50 |
| D2934 | PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN-PRIMARY TOOTH | 50/50 |
| D2940 | PROTECTIVE RESTORATION | 50/50 |
| D2950 | CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED | 50/50 |
| D2951 | PIN RETENTION, PER TOOTH, IN ADDITION TO RESTORATION | 50/50 |
| D2952 | POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED | 50/50 |
| D2954 | PREFABRICATED POST AND CORE IN ADDITION TO CROWN | 50/50 |
| D2960 | LABIAL VENEER (RESIN LAMINATE) – DIRECT | 50/50 |
| D2962 | LABIAL VENEER (PORCELAIN LAMINATE) – INDIRECT | 50/50 |
| D2971 | ADDITIONAL PROCEDURES TO CUSTOMIZE A CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK | 50/50 |
| D2975 | COPING | 50/50 |
| D3220 | THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)-REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT | 50/50 |
| D3230 | PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3240 | PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3310 | ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D3320 | ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3330 | ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3333 | INTERNAL ROOT REPAIR OF PERFORATION DEFECTS | 50/50 |
| D3346 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR | 50/50 |
| D3347 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID | 50/50 |
| D3348 | RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR | 50/50 |
| D3351 | APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC) | 50/50 |
| D3352 | APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC) | 50/50 |
| D3353 | APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC) | 50/50 |
| D3410 | APICOECTOMY-ANTERIOR | 50/50 |
| D3421 | APICOECTOMY-BICUSPID (FIRST ROOT) | 50/50 |
| D3425 | APICOECTOMY - MOLAR (FIRST ROOT) | 50/50 |
| D3426 | APICOECTOMY (EACH ADDITIONAL ROOT) | 50/50 |
| D3430 | RETROGRADE FILLING-PER ROOT | 50/50 |
| D3450 | ROOT AMPUTATION-PER ROOT | 50/50 |
| D3920 | HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D3950 | CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST | 50/50 |
| D4210 | GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 50/50 |
| D4249 | CLINICAL CROWN LENGTHENING-HARD TISSUE | 50/50 |
| D4260 | OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 50/50 |
| D4261 | OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 50/50 |
| D4266 | GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE | 50/50 |
| D4267 | GUIDED TISSUE REGENERATION, NATURAL TEETH – NON-RESORBABLE BARRIER, PER SITE | 50/50 |
| D4270 | PEDICLE SOFT TISSUE GRAFT PROCEDURE | 50/50 |
| D4273 | AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT | 50/50 |
| D4274 | DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA) | 50/50 |
| D4275 | NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT | 50/50 |
| D4277 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT | 50/50 |
| D4278 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE | 50/50 |
| D4283 | AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE | 50/50 |
| D4285 | NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT SURGICAL SITE AND DONOR MATERIAL)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE | 50/50 |
| D4341 | PERIODONTAL SCALING AND ROOT PLANING-FOUR OR MORE TEETH PER QUADRANT (4 TEETH WITH 4+MM POCKETS) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D4342 | PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT | 50/50 |
| D4346 | SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION | 50/50 |
| D4355 | FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT | 50/50 |
| D4381 | LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH | 50/50 |
| D4910 | PERIODONTAL MAINTENANCE | 50/50 |
| D5110 | COMPLETE DENTURE-MAXILLARY | 50/50 |
| D5120 | COMPLETE DENTURE-MANDIBULAR | 50/50 |
| D5130 | IMMEDIATE DENTURE-MAXILLARY | 50/50 |
| D5140 | IMMEDIATE DENTURE-MANDIBULAR | 50/50 |
| D5211 | MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 50/50 |
| D5212 | MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 50/50 |
| D5213 | MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5214 | MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5221 | IMMEDIATE MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5222 | IMMEDIATE MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5223 | IMMEDIATE MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D5224 | IMMEDIATE MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5225 | MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) | 50/50 |
| D5226 | MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) | 50/50 |
| D5282 | REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY | 50/50 |
| D5283 | REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR | 50/50 |
| D5511 | REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR | 50/50 |
| D5512 | REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY | 50/50 |
| D5520 | REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH) | 50/50 |
| D5611 | REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR | 50/50 |
| D5612 | REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY | 50/50 |
| D5621 | REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR | 50/50 |
| D5622 | REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY | 50/50 |
| D5630 | REPAIR OR REPLACE BROKEN CLASP-PER TOOTH | 50/50 |
| D5640 | REPLACE BROKEN TEETH-PER TOOTH | 50/50 |
| D5650 | ADD TOOTH TO EXISTING PARTIAL DENTURE | 50/50 |
| D5660 | ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D5670 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY) | 50/50 |
| D5671 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR) | 50/50 |
| D5710 | REBASE COMPLETE MAXILLARY DENTURE | 50/50 |
| D5711 | REBASE COMPLETE MANDIBULAR DENTURE | 50/50 |
| D5720 | REBASE MAXILLARY PARTIAL DENTURE | 50/50 |
| D5721 | REBASE MANDIBULAR PARTIAL DENTURE | 50/50 |
| D5730 | RELINE COMPLETE MAXILLARY DENTURE (DIRECT) | 50/50 |
| D5731 | RELINE COMPLETE MANDIBULAR DENTURE (DIRECT) | 50/50 |
| D5740 | RELINE MAXILLARY PARTIAL DENTURE (DIRECT) | 50/50 |
| D5741 | RELINE MANDIBULAR PARTIAL DENTURE (DIRECT) | 50/50 |
| D5750 | RELINE COMPLETE MAXILLARY DENTURE (INDIRECT) | 50/50 |
| D5751 | RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT) | 50/50 |
| D5760 | RELINE MAXILLARY PARTIAL DENTURE (INDIRECT) | 50/50 |
| D5761 | RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT) | 50/50 |
| D5810 | INTERIM COMPLETE DENTURE (MAXILLARY) | 50/50 |
| D5811 | INTERIM COMPLETE DENTURE (MANDIBULAR) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D5820 | INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY | 50/50 |
| D5821 | INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR | 50/50 |
| D5850 | TISSUE CONDITIONING, MAXILLARY | 50/50 |
| D5851 | TISSUE CONDITIONING, MANDIBULAR | 50/50 |
| D5863 | OVERDENTURE-COMPLETE MAXILLARY | 50/50 |
| D5864 | OVERDENTURE-PARTIAL MAXILLARY | 50/50 |
| D5865 | OVERDENTURE-COMPLETE MANDIBULAR | 50/50 |
| D5866 | OVERDENTURE-PARTIAL MANDIBULAR | 50/50 |
| D6058 | ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN | 50/50 |
| D6059 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) | 50/50 |
| D6060 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL) | 50/50 |
| D6061 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) | 50/50 |
| D6062 | ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL) | 50/50 |
| D6063 | ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL) | 50/50 |
| D6064 | ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL) | 50/50 |
| D6065 | IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D6066 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS | 50/50 |
| D6067 | IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS | 50/50 |
| D6068 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD | 50/50 |
| D6069 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL) | 50/50 |
| D6070 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL) | 50/50 |
| D6071 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL) | 50/50 |
| D6072 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL) | 50/50 |
| D6073 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL) | 50/50 |
| D6074 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL) | 50/50 |
| D6075 | IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD | 50/50 |
| D6076 | IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS | 50/50 |
| D6077 | IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS | 50/50 |
| D6082 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS | 50/50 |
| D6083 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS | 50/50 |
| D6084 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6086 | IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D6087 | IMPLANT SUPPORTED CROWN - NOBLE ALLOYS | 50/50 |
| D6088 | IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6092 | RE-CEMENT RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN | 50/50 |
| D6094 | ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6097 | ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6098 | IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS | 50/50 |
| D6099 | IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS | 50/50 |
| D6110 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MAXILLARY | 50/50 |
| D6111 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MANDIBULAR | 50/50 |
| D6112 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY | 50/50 |
| D6113 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR | 50/50 |
| D6114 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MAXILLARY | 50/50 |
| D6115 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MANDIBULAR | 50/50 |
| D6116 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY | 50/50 |
| D6117 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR | 50/50 |
| D6120 | IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D6194 | ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6195 | ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6210 | PONTIC-CAST HIGH NOBLE METAL | 50/50 |
| D6211 | PONTIC-CAST PREDOMINANTLY BASE METAL | 50/50 |
| D6212 | PONTIC-CAST NOBLE METAL | 50/50 |
| D6214 | PONTIC-TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6240 | PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL | 50/50 |
| D6241 | PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50/50 |
| D6242 | PONTIC-PORCELAIN FUSED TO NOBLE METAL | 50/50 |
| D6243 | PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6245 | PONTIC-PORCELAIN/CERAMIC | 50/50 |
| D6545 | RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS | 50/50 |
| D6548 | RETAINER-PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS | 50/50 |
| D6740 | RETAINER CROWN - PORCELAIN/CERAMIC | 50/50 |
| D6750 | RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL | 50/50 |
| D6751 | RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D6752 | RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL | 50/50 |
| D6753 | RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6780 | RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL | 50/50 |
| D6781 | RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL | 50/50 |
| D6782 | RETAINER CROWN - 3/4 CAST NOBLE METAL | 50/50 |
| D6783 | RETAINER CROWN - 3/4 PORCELAIN/CERAMIC | 50/50 |
| D6784 | RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6790 | RETAINER CROWN - FULL CAST HIGH NOBLE METAL | 50/50 |
| D6791 | RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL | 50/50 |
| D6792 | RETAINER CROWN - FULL CAST NOBLE METAL | 50/50 |
| D6794 | RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6930 | RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE | 50/50 |
| D6940 | STRESS BREAKER | 50/50 |
| D7111 | EXTRACTION, CORONAL REMNANTS-DECIDUOUS TOOTH | 50/50 |
| D7140 | EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL) | 50/50 |
| D7210 | SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D7220 | REMOVAL OF IMPACTED TOOTH-SOFT TISSUE | 50/50 |
| D7230 | REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY | 50/50 |
| D7240 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY | 50/50 |
| D7241 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS | 50/50 |
| D7250 | SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | 50/50 |
| D7251 | CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY | 50/50 |
| D7270 | TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH | 50/50 |
| D7280 | SURGICAL ACCESS OF AN UNERUPTED TOOTH | 50/50 |
| D7283 | PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH | 50/50 |
| D7284 | EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS | 50/50 |
| D7286 | INCISIONAL BIOPSY OF ORAL TISSUE-SOFT | 50/50 |
| D7291 | TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT | 50/50 |
| D7310 | ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT | 50/50 |
| D7311 | ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | 50/50 |
| D7320 | ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT | 50/50 |
| D7321 | ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D7340 | VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) | 50/50 |
| D7350 | VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE) | 50/50 |
| D7410 | EXCISION OF BENIGN LESION UP TO 1.25 CM | 50/50 |
| D7411 | EXCISION OF BENIGN LESION GREATER THAN 1.25 CM | 50/50 |
| D7450 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM | 50/50 |
| D7451 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM | 50/50 |
| D7471 | REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE) | 50/50 |
| D7472 | REMOVAL OF TORUS PALATINUS | 50/50 |
| D7473 | REMOVAL OF TORUS MANDIBULARIS | 50/50 |
| D7510 | INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE | 50/50 |
| D7511 | INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES) | 50/50 |
| D7830 | MANIPULATION UNDER ANESTHESIA | 50/50 |
| D7922 | PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN THE HEMOSTASIS OR CLOT STABILIZATION, PER SITE | 50/50 |
| D7961 | BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY) | 50/50 |
| D7962 | LINGUAL FRENECTOMY (FRENULECTOMY) | 50/50 |
| D7970 | EXCISION OF HYPERPLASTIC TISSUE-PER ARCH | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D7971 | EXCISION OF PERICORONAL GINGIVA | 50/50 |
| D7980 | SIALOLITHOTOMY | 50/50 |
| D8010 | LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION | 50/50 |
| D8020 | LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION | 50/50 |
| D8030 | LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION | 50/50 |
| D8040 | LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION | 50/50 |
| D8070 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION | 50/50 |
| D8080 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION | 50/50 |
| D8090 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION | 50/50 |
| D8210 | REMOVABLE APPLIANCE THERAPY | 50/50 |
| D8220 | FIXED APPLIANCE THERAPY | 50/50 |
| D9110 | PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT | 50/50 |
| D9222 | DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES | 50/50 |
| D9223 | DEEP SEDATION/GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT | 50/50 |
| D9230 | INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS (PER VISIT) | 50/50 |
| D9239 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D9243 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT | 50/50 |
| D9248 | NON-INTRAVENOUS CONSCIOUS SEDATION | 50/50 |
| D9941 | FABRICATION OF ATHLETIC MOUTHGUARD | 50/50 |
| D9944 | OCCLUSAL GUARD-HARD APPLIANCE, FULL ARCH | 50/50 |
| D9945 | OCCUSAL GUARD-SOFT APPLIANCE, FULL MOUTH | 50/50 |
| D9946 | OCCLUSAL GUARD-HARD APPLIANCE,PARTIAL ARCH | 50/50 |
| D9973 | EXTERNAL BLEACHING-PER TOOTH | 50/50 |
| D9974 | INTERNAL BLEACHING-PER TOOTH | 50/50 |
| D9995 | TELEDENTISTRY – SYNCHRONOUS - REAL-TIME ENCOUNTER | 100/100 |

# Plan General Exclusions, Limitations and Restrictions

Including provider supporting documentation requirements.

Eligibility is determined by the last date(s) of service and not based on a calendar or plan year. The last date(s) of service are determined by the prior completion date(s) in which the enrollee was eligible to receive benefits. Covered services for which a patient is not eligible, may be billed to the patient. Covered services that are disallowed by the plan, may not be billed to the patient.

| ADA Range | Limitations/Exclusions |
|---|---|
| D0120, D0145, D0160, D0170 | Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0140 | An evaluation limited to a specific oral health problem or complaint. The use of this procedure code is also appropriate in dental emergencies, trauma, acute infection, etc. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0150, D0180 | Eligible only once every 4 years. D0180 applies to age 14 and above. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0210, D0709 | A complete series includes bitewings. Eligible only once per 4 years. Not eligible if performed within 4 years of D0330, D0701 or D0709. If D0210 is performed within 12 months of D0270, D0272, D0273, D0274, D0708 the allowable amount for D0210 will be reduced by the charges for D0270, D0272, D0273, D0274, D0708. Not eligible if performed within 12 months of D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0220, D0230, D0707 | Eligible for a maximum of 3 during a 12 month period. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0240 | Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0706. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0270, D0708 | "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210, D0277 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D0272, D0273 | Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. |
| D0274 | "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. |
| D0277 | Not eligible if performed within 12 months of D0210 or D0274. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0320, D0321 | Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0330, D0701 | Eligible only once per 4 years. Not eligible if performed within 4 years of D0210, D0701 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0340 | Eligible only once per 2 years. Not eligible if performed within 2 years of D0702. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D0350, D0703 | Eligible only once per 5 years. Not eligible if performed within 4 years of D0703. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D0460 | Eligible for one charge per date of service. |
| D0470 | Eligible only once per 5 years. It is included in the charges for complete or partial dentures, separate charges are disallowed. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D0702 | Eligible only once per 2 years. Not eligible if performed within 2 years of D0340. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D0706 | Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0240. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D1110, D1120 | Not eligible for more than 2 cleanings per 12 consecutive month period which includes utilization of codes D4341, D4346, D4355, or D4910. Reimbursement for D1120 is limited to enrollees under the age of 14. |
| D1206 | Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Eligible only for children under 14 years of age. |
| D1208 | Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Age limitation may apply. |
| D1351 | Eligible on permanent molar teeth (per tooth) only. Not eligible for replacement for a period of 5 years. Eligible only for children under 15 years of age. Not eligible for a restoration on the O, OB, or OL surfaces following the placement of a sealant on that surface or if a restoration involving the O surfaces has been performed for a period of 3 years. |
| D1510, D1516, D1517, D1520, D1526, D1527, D1575 | Eligible only for children under 13 years of age. Not eligible if performed within 3 years of D1510, D1515, D1520, D1525, or D1575. |
| D1551, D1552, D1553 | Not eligible within 12 months of the initial placement of the space maintainer. Eligible once per 12 months. |
| D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394 | Not eligible for the replacement of or an additional restoration on the same surface for a period of 2 years. Not eligible if performed within 3 years of placing a crown on the same tooth or a sealant on the same surface within 3 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2651, D2652, D2662, D2663, D2664, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794 | Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed. |
| D2650 | Not eligible for a replacement by any type of inlay, onlay, or crown for 7 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed. |
| D2710 | Eligible on anterior teeth only. Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed. |
| D2910, D2915, D2920, D6092 | Not eligible for the recementation of an inlay, onlay, or crown within 12 months of the original cementation. Eligible once per 12 months. |
| D2930, D2931, D2933, D2934 | Charges are subject to the same restrictions and conditions as D2520 through D2794. |
| D2940 | Not eligible for replacement by another protective restoration for a period of 3 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for definitive treatment are subject to an adjustment if performed within 12 months of D2940. |
| D2950 | Not eligible within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for core buildups requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed. |
| D2951 | Charge is per tooth and limited to posterior teeth only. Additional pins will be disallowed. |
| D2952, D2954 | Not eligible if performed within 7 years of D2950, D2952, or D2954. Eligible once per 7 years per tooth. Not allowable without history of root canal therapy. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D2960 | Not eligible for a replacement for 3 years. Placement is restricted to anterior permanent teeth only. |
| D2962 | Not eligible for a replacement for 7 years. Placement is restricted to anterior permanent teeth only. Charges for veneered crowns replacing labial veneers (porcelain) are not allowable for 7 years. |
| D3220 | Eligible for primary teeth only and only once per tooth. Charges are exclusive of the final restoration charge. |
| D3230 | Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3240 | Eligible on primary posterior teeth only. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3310, D3320, D3330, D3333, D3346, D3347, D3348 | Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3351, D3352, D3353 | Limited to children under 16 years of age. Eligible once per lifetime. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3410, D3421, D3425, D3426, D3430, D3450, D3920 | Eligible once per lifetime. |
| D3950 | Eligible once per 7 years. Charges will be disallowed if submitted in conjunction with D2952, D2953, D2954, or D2957. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D4210, D4260, D4261 | Eligible only once per area treated for a 5 year period. |
| D4249 | Eligible only once on a per tooth basis. Eligible only once per tooth per lifetime. |
| D4266, D4267 | Charges include the charge for the barrier, and its removal, if necessary. Eligible only once per area treated for a 5 year period. |
| D4270, D4273, D4275, D4277, D4278 | Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. Eligible only once per area treated for a 5 year period. |
| D4274 | Eligible only when this procedure is performed in an edentulous area adjacent to a periodontally involved tooth. The tooth and proximal area must be identified. Eligible only if no additional surgery is performed in the immediate area, eligible every 5 years. Eligible only once per area treated for a 5 year period. |
| D4283, D4285 | Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. |
| D4341 | Eligible per quadrant (4 or more active periodontal diseased and qualified teeth). The enrollee must exhibit pocket depths of at least 4 mm around at least 4 teeth in each quadrant to qualify for coverage for this procedure. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements. |
| D4342 | Eligible per quadrant (1 to 3 active periodontal diseased and qualified teeth). The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements. |
| D4346 | Eligible only for enrollees over 15 years of age. Eligible once per 5 years. Not eligible within 6 months of or same date of service as D1110, D1120, D4341/D4342 (quadrant allottment may apply), D4355, or D4910. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D4355 | Eligible only for enrollees over 15 years of age. To be eligible, procedure must be performed before and not on the same date of service as D1110, D4341, D4342, D4346, or D4910, or more than 3 years has lapsed since D1110, D4341, D4342, D4346, D4355, or D4910 was performed. |
| D4381 | Eligible once per 5 years. |
| D4910 | Not eligible if performed within 6 months of or same date of service as D1110, D1120, D4341/D4342 if four quadrants were treated, D4346 or D4355. Not eligible for more than 2 per 12 consecutive month period. Eligible only for enrollees over 15 years of age. |
| D5110, D5120, D5282, D5283 | Not eligible for the replacement of a denture, including an immediate or partial denture, within 7 years. Separate charges for diagnostic casts (D0470) are disallowed. Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch or of any repairs, relines, rebases (D5510 through D5761). |
| D5130, D5140 | An immediate denture cannot be used to replace a complete denture. Other restrictions are the same as D5110 & D5120. |
| D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226 | Eligible every 7 years and are subject to the same conditions and restrictions listed for D5110 & D5120. Separate charges for diagnostic casts (D0470) are disallowed. The teeth replaced by the appliance must be identified on the claim form. |
| D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660 | Not eligible if the procedure is performed within 6 months of the date of delivery of the appliance. Eligible once per procedure code per 6 months. |
| D5670, D5671 | Eligible only once per 4 years per prosthesis. Not eligible if performed within 4 years of D5213 or D5214. Not eligible for charges for rebase, reline or repairs for 6 months. |
| D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761 | Not eligible within 6 months of the date of delivery of the appliance except when an immediate partial/denture is performed. Eligible for any of these procedures only once per 4 years per prosthesis. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D5810, D5811 | Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim complete denture (D5810 & D5811) in the same arch. |
| D5820, D5821 | Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch. |
| D5850, D5851 | Eligible for two tissue conditioning charges within 6 months of delivery of immediate partial/denture only. |
| D5863, D5864, D5865, D5866 | Charges are subject to the conditions listed for D5110/D5120 and D5213/D5214. |
| D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6194, D6195 | Charges are subject to the same definitions and restrictions listed for D2710 thru D2794 and D6210 thru D6974. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. |
| D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117 | Charges are subject to the same definitions and restrictions listed for D5110 thru D5866. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. |
| D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6545, D6548, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794 | Charges are subject to the same definitions and restrictions listed for D2520 thru D2794. Each unit of a fixed partial denture must be identified on the claim. Not eligible for pontics to replace third molars. All fix prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 7 years of the original placement. |
| D6930 | Not eligible within 12 months of the original cementation. Eligible only once per 12 months per fixed partial denture. |
| D7210, D7250 | Surgical extractions: use when either (1) removal of bone and/or (2) sectioning of tooth, including elevation of mucoperiosteal flap if indicated, is necessary. Surgical extraction charges include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed. |

| ADA Range | Limitations/Exclusions |
| --- | --- |
| D7280, D7283 | Eligible once per lifetime. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D7284, D7286 | Charges will be disallowed in performed in conjunction with D3410, D3421, D3425, D3426, or D3427. |
| D7291 | Eligible on anterior permanent teeth and bicuspids. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D7310, D7311 | Charges are subject to review if performed in conjunction with D7210 thru D7250. Charges not meeting generally accepted standards of care will be disallowed (see D7210 thru D7250). |
| D7340, D7350 | Charges filed in conjunction with implant services will be disallowed. |
| D7473 | Eligible once per arch per lifetime. |
| D7510 | Charges filed in conjunction with definitive treatment will be disallowed. |
| D7922 | Not eligible for more than a combination of two D7922 or D9110 per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed. |
| D7961, D7962 | Eligible once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D7971 | Charges filed in conjunction with definitive restorative treatment will be disallowed. |
| D9110 | Not eligible for more than two palliative (emergency) treatments per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed. |
| D9222, D9223, D9239, D9243 | Limited to a total of 30 minutes per date of service. |
| D9230 | Eligible once per date of service. |
| D9941 | Eligible once per 12 months. |
| D9944, D9945, D9946 | Occlusal guards are removable dental appliances designed to minimize the effects of bruxism and other occlusal factors. Eligible once every 5 years. Charges to modify the appliance or for occlusal adjustment are not eligible. |
| D9973 | Eligible on anterior teeth only. Not eligible for retreatment within 3 years of the date of the previous treatment series. Not eligible for home bleaching trays and procedures. |
| D9974 | Eligible on anterior teeth only with history of root canal therapy. Not eligible for retreatment within 3 years of the date of the previous treatment series. Not eligible for home bleaching trays and procedures. |
| D9995 | Eligible one per 12 months. |

# Orthodontic Benefit Rider

**Covered Orthodontic Benefits**

Not all plans include benefits for orthodontic treatment. Orthodontic benefits, if included in the dental plan, cover certain orthodontic services and follow certain administration policies as indicated below.

The Standard Plan benefit covers the following orthodontic services:

| | |
|---|---|
| Limited Orthodontic Treatment | Interceptive Orthodontic Treatment |
| Comprehensive Orthodontic Treatment | Minor Treatment to Control Harmful Habits |

1. The dentist providing orthodontic services must file an initial claim form on behalf of the member and identify when services began, the anticipated length of the treatment period and the total cost of the treatment plan.

2. The Plan will indicate which Plan members qualify for the benefit and/or to what age the member is covered. The Standard Plan benefit covers only dependent children to a certain age, regardless of any treatment that may be in progress. Some Plans also cover adults.

3. The Plan will indicate the payment cycle for which benefits are paid. The Standard Plan benefit payment cycle makes payments of equal installments directly to the dentist on a monthly basis over a period of 24 months. The member must be an active member and be in active treatment during the entire 24 months to receive the full lifetime orthodontic benefit. If the treatment period is less than 24 months, the member's benefit will be paid only over the active treatment period and the full benefit will not be realized. If a non- standard payment cycle is selected, such as over the course of the treatment plan designated with the original claim filing, the terms will be indicated in the Plan. In the event a treatment plan is not defined with the original claim filing, the plan payment cycle will default to 24 months.

4. Active treatment is defined as treatment requiring periodic visits resulting in the movement and retention of teeth.

5. The Plan will indicate the coinsurance percentage that the member is responsible for. The Plan coinsurance may be different based on whether the dentist is a participating network or out of network dentist/orthodontist.

6. The Plan will indicate the amount of the Lifetime Orthodontic Maximum Benefit. A lifetime maximum benefit is the maximum amount paid on behalf of a member during that member's lifetime, regardless of whether a previous employer or carrier paid for the services (subject to availability of claim's information). A member is responsible for the difference between the lifetime maximum and the dentist's fee.

7. Members enrolled after the placement of braces may be eligible to receive benefits for the treatment in progress. The Plan will only consider a benefit based on the remainder of the treatment plan and will require the dentist to submit a claim for the remaining treatment plan. The member's benefit will be paid only over the remaining active treatment period and the full benefit may not be realized.

8. The Orthodontic benefit does not include benefits for lost, stolen, repairs, re-cementation, or replacement retainers. The benefit does not cover the removal of appliances for reasons other than completion of treatment.

9. Orthodontic benefits are paid "monthly" over a period of time and at the designated Plan payment amount in effect at the inception of the member's Orthodontic treatment plan. Adjustments to monthly payments will be made if the Plan Lifetime Annual benefit changes (increases or decreased) during the course of an existing treatment plan. This adjustment will only affect Plans with the Standard Benefit feature. Plans that pay benefits over a treatment plan personal to that member will "lock in" at the inception of a member's treatment plan and will not adjust over the course of the treatment as long as the Plan covers an Orthodontic Benefit. No lump sum payments will be made for any reason.

PARAMOUNT
DENTAL
*Affiliate of ProMedica*

1.3432-D.R033023.LR

© 2023 Health Resources Inc.

Paramount Dental Plan

Forest River Out of Network
Group Number 379283275020

# Certificate of Coverage

PARAMOUNT DENTAL
*Affiliate of ProMedica*

Insurance products are marketed by Paramount Dental and underwritten and administered by Health Resources Inc.

This Handbook along with your Summary of Dental Plan Benefits, describes the specific benefits of your Paramount Dental Plan and how to use them.

Visit Paramount Dental Online 24 hours a day/7 days a week at InsuringSmiles.com

Contact Member Services
Paramount Dental
7:00 am – 7:00 pm CST Monday through Friday 800.727.1444
P.O. Box 659, Evansville, IN 47704-0659

# DENTAL PLAN HANDBOOK & CERTIFICATE OF INSURANCE

| | |
|---|---|
| Welcome to Your Paramount Dental Plan | 4 |
| Definitions | 4 |
| Eligibility | 7 |
| Enrollment Periods | 7 |
| Web Services | 8 |
| Member ID Card | 8 |
| Benefit Categories - What is Covered by my Plan? | 8 |
| Coinsurace | 9 |
| Plan Features | 9 |
| Service Exclusions | 10 |
| Service Limitations | 11 |
| Disallowed Services | 14 |
| How Payment Is Made | 14 |
| Notice of Claim | 15 |
| Claim Forms | 15 |
| Proof of Loss | 15 |
| Time of Payment of Claims | 16 |
| Legal Actions | 16 |
| Coordination of Benefits | 16 |
| Right of Recovery | 18 |
| Termination of Coverage | 18 |
| Continuation of Coverage | 18 |
| Questions and Assistance | 20 |
| General Conditions and Additional Information | 20 |
| Entire Contract & Changes | 20 |
| Claims Appeal Procedure | 20 |
| Notice of Privacy Practices | 21 |
| Physical Examinations and Autopsy | 22 |
| ERISA | 22 |
| Grace Period | 22 |
| Notification to Insureds | 23 |
| Misstatement of Age | 23 |
| Incontestability | 23 |
| Conformity with State Statutes | 23 |
| Benefit Details | 24 |
| Plan General Exclusions, Limitations and Restrictions | 44 |
| Orthodontic Benefit Rider | 54 |

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY

Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary of Dental Plan Benefits conflicts with a statement in this Certificate, the statement in the Summary of Dental Plan Benefits applies to this plan and you should ignore the conflicting statement in this Certificate.

## Language Assistance

| | |
|---|---|
| **English** | ATTENTION: If you speak English, free language assistance services are available. Call 1-800-727-1444 (TTY: 711). |
| **Español**<br>Spanish | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-727-1444 (TTY: 711). |
| **繁體中文**<br>Chinese | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-727-1444 (TTY 711）。 |
| **Tiếng Việt**<br>Vietnamese | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-727-1444 (TTY: 711). |
| **Tagalog**<br>Tagalog – Filipino | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-727-1444 (TTY: 711). |
| **한국어**<br>Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-727-1444 (TTY: 711) 번으로 전화해 주십시오. |
| **العربية**<br>Arabic | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1444 -727-800-1<br>(رقم هاتف الصم والبكم: 711) |
| **Հայերեն**<br>Armenian | ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-727-1444 (TTY (հեռատիպ)՝ 711): |
| **Русский**<br>Russian | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-727-1444 (телетайп: 711). |
| 日本語<br>Japanese | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-727-1444（TTY: 711）まで、お電話にてご連絡ください。 |
| **فارسی**<br>Farsi | **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-727-1444 (TTY: 711) تماس بگیرید. |
| **ਪੰਜਾਬੀ**<br>Panjabi | ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-727-1444 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। |
| **ខ្មែរ**<br>Cambodian | ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-727-1444 (TTY: 711)។ |
| **Hmoob**<br>Hmong | LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-727-1444 (TTY: 711). |
| **हिंदी**<br>Hindi | ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-727-1444 (TTY: 711) पर कॉल करें। |
| **Deutsch**<br>German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-727-1444 (TTY: 711). |
| **ภาษาไทย**<br>Thai | เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-727-1444 (TTY: 711). |
| **Deitsch**<br>Pennsylvania Dutch | Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-727-1444 (TTY: 711). |
| **ܣܘܪܝܝܐ**<br>Syriac | ܫܝܢܐ ܠܟ ܕܡܢ ܫܘܠܛܢܐ ܐܝܬ ܠܟ ܫܝܫܬ ܫܘܠܛܢ ܕܡܫܬܡܫ ܒܠܫܢ

## Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

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

Paramount provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Paramount Member Services at 1-800-727-1444, for TTY users, 711, 7:00 a.m. to 7:00 p.m. CST, Monday through Friday.

If you believe that Paramount has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by phone, mail, fax, or email.

Paramount Dental
1449 Kimber Lane
Ste 103
Evansville, IN 47715

Phone: 1-800-727-1444
TTY: 711
Fax: 812-401-3609
Email: Claims@InsuringSmiles.com

If you need help filing a grievance, Member Services is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW
Room 509F, HHH Building Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

# Welcome to Your Paramount Dental Plan

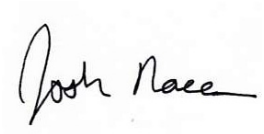
Thank you for enrolling in Paramount Dental! Oral health is a vital part of overall health, and it is our pleasure to be included in your wellness culture. Paramount Dental collaborates with the dental profession to design dental plans that promote oral health care along the most cost effective path. As any dental care professional will attest, the key to avoiding costly dental problems is prevention which starts with you and utilizing the preventive benefits included in your plan. We recommend making your first appointment as soon as possible to ensure you are on the road to great oral health!

You have a wide choice of Network Dentists, both generalists and specialists, nationwide! Network Dentists submit claim forms for services performed for you and payments are paid directly to them. Network Dentists also sign contracts with Paramount Dental to accept certain agreed upon fees, therefore, you and your employer may realize significant savings.

Paramount Dental is also committed to providing the highest quality member services to all Members. Our dedicated team members are available toll-free, Monday through Friday. You may also access information through our website, InsuringSmiles.com. It is your responsibility to be informed about Your Benefits and any associated Limitations and Restrictions, so please read and save this booklet for reference.

Our mission is to offer dental plans that "Improve Your Health and Well-Being". Since 1986, that is exactly what we have delivered to Our Members. We look forward to continuing that promise to our customers.

Sincerely,



Joshua Nace
President - Paramount Dental

This Certificate of Coverage (referred to herein as Certificate) is part of the Master Group Policy that is a legal document (a contract) between Paramount Dental and the Employer. (Referred to herein as We, Us, Our, Paramount Dental, or the Company) and Your Employer Group (referred to herein as Employer) to provide Benefits to Eligible Members (referred to herein as you or your) and is subject to the terms, conditions, Limitations and Exclusions of the Policy. Reasonable effort has been made for this Certificate to represent the intent of the Master Group Policy language between Paramount Dental and Your employer.

Paramount Dental issues this Certificate based on Your Employer Group's Master Group Policy and payment of the required Policy charges. In addition to this Certificate, the Policy includes:

- The Master Group Policy
- Employer Application
- The Summary of Dental Plan Benefits
- Riders
- Amendments

# Definitions

**Adverse Determination**
Any denial, reduction or termination, or a failure to provide or to make payment (in whole or part) of the benefit sought.

**Balance Billing**
Network Dentists agree to accept the network's contracted fees as payment in full. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as "balance billing" and is not enforceable for Out-Of-Network Dentist as they are under no obligation to limit their fees.

**Benefits**
The amounts that the Plan pays for Covered Services under a Member's dental Plan. Benefits may be available whether through teledentistry or face-to-face with your Dentist.

**Benefit Plan Year**
The plan year, unless your employer or organization elects a different period to serve as the Benefit Year.
(See the Summary of Dental Plan Benefits for your Benefit Year.)

**Children or Child**
Your natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with you during the waiting period for adoption or legal guardianship.

**Claim/Claim Form**
Standard statement of dental services performed that is submitted by a Dentist or Member to request payment from the Payor. Network dentists always file claim forms on behalf of members and accept payment directly from the Payor. Claim forms are also used to request a pretreatment estimate.

**Completion Dates**
The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;

- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

**Copayment / Coinsurance**
The Member's share, expressed as a fixed percentage, of the covered dental service.

**Coordination of Benefits (COB)**
A process that carriers use to determine the order of payment and amount each carrier will pay when a person receives dental services that are covered by more than one benefit plan. COB ensures that no more than 100 percent of the lowest allowable charges for services are paid when a member has coverage under two or more benefits plans (dual coverage) – for example, a child who is covered by both parents' plans.

**Covered Services**
Dental care services for which a reimbursement is available under a Member's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

**Custodial Parent**
The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the plan year excluding any temporary visitation.

**Deductible**
The amount a person and/or a family must pay toward Covered Services before Paramount Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

**Deny/Denied**
If a service is denied, the service is not considered a benefit of the patient's coverage and the allowable amount is collectible from the patient.

**Dentist**
Dental care provider who is skilled in and licensed to practice the prevention, diagnosis, and treatment of diseases, injuries, and malformations of the teeth, jaws, and mouth and who makes and inserts false teeth.

**Dependent/Dependent Child**
Any Member of a Subscriber's family who meets all the applicable Eligibility requirements, has been enrolled in the plan and for whom the payment required by the employer's group agreement has been received by Paramount Dental.

Dependent Child may include the enrolled employee's biological child, stepchildren, adopted children placed with the enrolled employee whether or not the adoption is final, foster children, children subject to legal court or administrative order to provide health coverage.

Dependent Child also includes any child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. We reserve the right to require proof of incapacity, but not more than annually following the two year period after the child attains limiting age.

**Disallow(ed)**
If a service is disallowed, the fee is not collectible from the patient by a Network Dentist or the plan.

**Effective Date**
The date a dental benefits policy begins. Effective date may also be used to describe the date that benefits begin for a Member. The Effective Date is determined in accordance with waiting periods and employment terms enforced by the employer group and applicable State and Federal regulatory entities.

**Eligibility**
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer.

**Eligible Persons –**
**(Employees + Spouses + Dependents)**
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer. Generally, Eligible persons typically include your legal spouses and dependents.

Paramount Dental will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. Dependent children are subject to the employer group's dependent age limitation, which must be no less than age 26.

Dependent child may include the Enrolled Employee's biological children, stepchildren, adopted children, foster children, children subject to legal guardianship, newborn children, or any child for whom the Member is the legal guardian or is required by a court or administrative order to provide health coverage. Coverage for adopted children is effective upon the earlier of: the date of placement or the date of entry of an order granting custody.

**Exclusions**
Services that are not covered under the Employer Group Dental Insurance Plan.

**Explanation of Benefits (EOB)**
The statement received after a claim is processed, detailing how Your claim was processed, including

identification of services rendered, fees, application of plan Limitations, calculation of Plan payment, and the amount for which you are responsible.

### Fee Charged
The amount that the Dentist bills and is entered on a claim as the charge for a specific service.

### Handbook
This document. Paramount Dental will provide Benefits as described in this Handbook. It also serves as your Certificate of Coverage. Any changes in this Handbook will be based on changes to the contract, including the Summary Plan Dental Benefits, between Paramount Dental and your employer or organization.

### Lifetime Maximum
The cumulative dollar amount that a plan will pay for dental care incurred by an individual Member for the life of the Member. Lifetime maximums usually apply to specific services such as orthodontic treatment.

### Limitations
A list of conditions or circumstances that limit or exclude services from Plan coverage.

Limitations may be related to time or frequency (the number of services permitted during a stated period).

### Master Group Policy
The written, legally binding agreement between Paramount Dental and an Employer Group.

### Maximum Allowable Amount
The maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meets our definitions of a Covered Service. The maximum allowable/expense is determined by a) the lesser fee of the primary or secondary insurance carrier as it applies to network participation, associated agreed discounts and patient responsibility or b) the fee considered for the global service. For network Dentists, this is the dollar amount that the attending Dentist has agreed to accept as payment in full for the plan and the patient. This amount is shown on the notice that accompanies payment of the claim.

### Maximum Allowable Fee
The Maximum Allowable fee amount is the maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meet our definitions of a Covered Service. For Network participating Dentists, the Maximum Allowed Amount will be reimbursed according to a Schedule of Maximum Allowable Charges. Unless specified within the Summary of Dental Plan Benefits of this Policy, the Maximum Allowed Amount for Out-Of-Network Dentists will be reimbursed according to a Table of Allowances as specified in your Summary of Plan Benefits. Paramount Dental's portion of payment for each covered service is the lesser of the Dentist's fee or the maximum allowable fee, minus the co-insurance.

### Plan Annual Maximum Benefit
The total maximum dollar amount the Employer Group Paramount Dental Plan will pay toward the cost of dental care incurred by an individual Member in a Plan Year.

### Member
A person covered under the Employer Group Paramount Dental Plan. There are two subsets of Members: The Primary Member who is the Employer Group Member under whom the family is enrolled, and the enrolled family members including spouse, domestic partner and eligible children.

### Network Dentist
A dentist who contracts with Paramount Dental or leased network carrier and agrees to accept contracted fees as payment in full and abide by certain administrative guidelines.

### Network
A panel of Dentists that contractually agree to provide treatment according to administrative guidelines, including limits to the fees accepted as payment in full.

### Open Enrollment Period
A period (usually a two-week or one-month period during the year) when qualified individuals (eligible employees) can enroll in or change their choice of coverage in-group benefits plans.

### Out of Network Dentist
A dentist who does not contract with Paramount Dental to participate in the network and the associated administrative guidelines including claim submission requirements and maximum allowable fee capitations.

### Patient Responsibility
The portion of a Dentist's fee that a Member must pay for dental services, including deductible, coinsurance, any amount over plan maximums, services the plan does not cover and covered services for which the patient is not eligible.

### Plan Administrator
The Employer/Sponsor of the Plan or such third party hired by the Employer/Sponsor who performs certain activities for the Plan.

### Pre-Authorization
A requirement that recommended treatment must first be approved by the Plan before the treatment is rendered in order for the Plan to pay benefits for those Covered Services.

### Premiums

The money billed and paid to Paramount Dental for each month of dental coverage. Payment must be made by an Employer group in order for claims to be paid.

**Pre-Treatment Estimate**
A non-binding estimate of the benefits available and patient responsibility for a proposed treatment plan after the application of Plan Limitations, restrictions, and exclusions, remaining plan annual maximum and determination of Covered Services.

**Qualifying Event**
Change in marital status, change in the number of dependents, or change in employment status.

**Resin/Composite**
Tooth-colored filling material. Although cosmetically superior, it is less durable than other materials.

**Submitted/Billed Amount**
The amount a Dentist bills to Paramount Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the amount Paramount Dental approves for the treatment.

**Subscriber**
You, when your employer or organization notifies Paramount Dental that you are eligible to receive Benefits under This Plan.

**Summary of Dental Plan Benefits**
A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

**Waiting Period for Plan Eligibility and For Covered Services**
Waiting periods are designated by an Employer Group. If an Employer Group establishes a plan-waiting period, it is the stated period of time that a Member must be enrolled in the Plan before being eligible for benefits or for a specific category of benefits. A waiting period limits reimbursement for various services until the insured has been covered for a specific amount of time. Waiting period can apply to specific/individual procedures as well as at the group level.

# Eligibility

Paramount Dental is available through employers for their employees. Your Employer selected the Plan and the level of coverage available for You and Your dependents. Coverage provided under the Plan for Employees and their Dependents shall be in accordance with their Eligibility, Effective Date, and Termination provisions of the Plan, including any coverage classifications. For more information, please contact Your Benefits Administrator.

Paramount Dental. Will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight.

**Qualified Medical Child Support Order (QMCSO)**
Under certain circumstances, You might be required to provide coverage for a child even if You do not have custody, or if the child is not Your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMSCO). An Employee who is ordered by a QMSCO to provide dental coverage for a child may enroll himself and such child under the Plan. If Your spouse also has dental insurance, he/she may enroll under your plan but special rules apply (see Coordination of Benefits).

**Extended Coverage for a Dependent Child**
Paramount Dental will acknowledge each individual Employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. If You have dependent(s) with a permanent physical disability or mental disability to the extent they cannot support themselves, they may qualify for coverage beyond the applicable age limit for dependent(s). In order to extend coverage, You must provide Us with proof of the child's incapacity and dependency within 120 days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the 2 year period following the child's attainment of the limiting age.

To request special enrollment or obtain more information, contact your Benefits Administrator or Paramount Dental member services.

# Enrollment Periods

**Initial Enrollment**
At the time You enroll, You are given a coverage Effective Date. Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. You must notify Your employer if You have a change of marital status or other Qualifying Event relating to You or Your dependents within thirty (30) days from the time the Qualifying Event occurs. Otherwise, changes may be made only at Open Enrollment or Plan renewal.

**Open Enrollment**
Open Enrollment is designated by the Employer and is usually the thirty (30) day period immediately preceding the renewal date of Your Employer's policy with Paramount Dental. During this period, You may drop Your coverage or change dependent coverage. Any changes will be effective on the renewal date of Your Paramount Dental Plan.

**Special Enrollment**
Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. A special enrollment period can occur if an Eligible Employee or Dependent(s) loses coverage under another health plan. A special enrollment period may also begin when Dependent (s) become newly eligible due to marriage, birth, court order, adoption or placement of a child in the home of the Eligible Employee.

The Eligible Employee must request enrollment within 30 days of the Qualifying Event date. During the Special Enrollment Period, the Employee may enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also enroll any newly eligible Dependent(s) of the Employee under the Plan.

## Web Services

Paramount Dental offers information and various services on its website. The website is continually revised, improved and enhanced for Your convenience. Members may:

- Find a Network Dentist,
- Verify benefit plan, renewal dates, dependent coverage, Claim status,
- Print Member Cards,
- Review benefit history,
- Download brochures and Certificates, and
- Acquire oral health and wellness tips.

Online materials serve as the primary source of information for groups, Members, dentists and advisers. Any printed documents that you may have is based on information at a certain point in time and may not be inclusive of all benefits, restrictions and limitations. All documents may also be requested by contacting our Customer Service Center at: 1-800-727-1444.

## Member ID Card

A Paramount Dental Member ID Card will be issued to you upon enrollment.

## Selecting a Dentist – Receiving Dental Care

Dentistry is a highly personal service. You may have any dental treatment performed as decided by You and Your dentist. Your Dental Plan does not dictate what treatment You receive. Only You and Your dentist can determine that. However, Your Plan does determine what services are covered and by what type of dentist (In-Network vs. Out-of-Network). The coverage selected by Your Employer pays for only those Covered Services under Your Paramount Dental Plan listed in this certificate and Summary of Dental Benefits within the Limitations and restrictions presented. You must personally pay for any service which is not covered or for any service that is covered but is subject to Limitations and restrictions. Your Claim will only be processed after completion of the dental service. If You are not sure whether a particular dental treatment is covered or how much You will be required to pay, You may request a Pre-Treatment Estimate from Your dentist. It is a free service offered by Paramount Dental and highly encouraged so you are never surprised about your dental coverage.

Some services are limited by the age of the patient, by how often the service may be performed, or by specific teeth. All time intervals (frequency limitations) required by coverage are independent of calendar year or plan year. Frequency limitations regarding how often services may be performed are continuous. Change of dental plan coverage, termination and reinstatement of coverage does not eliminate the frequency limitations.

Paramount Dental also offers a large, nationwide, network of credentialed dentists to accommodate oral health needs of You and Your family. Simply visit the Find a Dentist link on InsuringSmiles.com, to view a complete listing of general and specialty Network Dentists in Your geographical area. The Network listing generated from the website includes access to all Paramount Dental and leased Networks included in your Plan offered by your Employer that is outlined your Summary of Dental Benefits. Network Dentists provide the same excellent service at a contracted fee, resulting in savings for You and Your family.

You should always verify the plan and your Summary of Dental Plan Benefits selected by Your Employer prior to Your dental visit as it makes a difference in Your coinsurance and savings. Network Dentists are independent contractors and are not Paramount Dental employees.

## Benefit Categories – What is Covered by My Plan?

**Important** - It is very important to understand that your employer will select which plan services are included in your plan. Please review both this Certificate and the Summary of

Dental Plan Benefits carefully. **ONLY the dental services listed in your Summary of Dental Plan Benefits will be covered by your plan.** The Summary of Dental Plan Benefits is part of this Certificate and supersedes any provision of this Certificate. Covered services are also subject to exclusions and limitations and are included in a later section of this certificate.

The various dental services provided by a dentist are classified into the following categories:

1. Diagnostic and Preventative
2. Restorative
3. Endodontic
4. Periodontics
5. Prosthodontics (removable and fixed)
6. Oral Surgery
7. Orthodontics
8. Adjunctive

### Diagnostic and Preventive Services

These services are important to your overall oral health and the detection and prevention of dental disease. They include examinations and evaluations (routine and problem focused), prophylaxes (routine teeth cleanings), radiographs (x-rays), fluoride treatments, and sealants and space maintainers (for children).

### Restorative Services

- Minor Restorative Services – these procedures rebuild and repair your teeth damaged by disease, decay, fracture or injury. Both amalgam (silver) and composite (white tooth colored) fillings on baby and adult teeth and anterior and posterior teeth are considered in this category.
- Major Restorative Services – these services include crowns and crown related services. Crowns may be covering a natural tooth or an implant.

### Endodontic Services

These procedures treat teeth with diseased or damaged nerves. Root canals are included in this category.

### Periodontic Services

- **Non-surgical Periodontics Services** – these procedures involve the treatment of diseases of the gums and supporting structures of the teeth. Nonsurgical procedures include periodontal scaling and root planning, full mouth debridement and periodontal maintenance following a periodontal therapy (periodontal cleanings).
- Surgical Periodontal Services – procedures that related to surgery of your gums which can include osseous surgery and gingivectomy.

### Prosthodontic Services (fixed and removable)

- Bridges, partial and complete dentures are in this category.
- Relines and Repairs – these procedures reline and repair existing dentures (partial and complete) and repair existing bridges.
- Implant Services – the placement of an endosteal implant and the associated abutment.

### Oral Surgery

- Simple Extractions – this procedure is an extraction of a tooth that is erupted or exposed root.
- Surgical extractions of tooth/teeth are included in this category and include the removal of impacted teeth and other extractions including removal of bone. An incisional biopsy of oral tissue for the detection of cancer or other suspected disease is also included in oral surgery services.

### Adjunctive/Other Services

Your Summary of Dental Plan Benefits will list any other benefits that may have been selected.

### Orthodontic Services

A “Rider” to your Plan must be selected and included in your Summary of Dental Plan Benefits to have Orthodontic Services covered. Orthodontic covers traditional braces, clear orthodontic treatment (Invisalign) and removable appliances. Retainers are considered part of the orthodontic treatment.

### How Payment is Made for These Benefits Categories

When filing claims, your dental office will use the appropriate dental code(s) found in the American Dental Association’s current CDT Code Book. The codes are too numerous to list, however the staff at your dental office is well versed in using these codes and the staff can explain them more thoroughly at your request.

It is best, though not necessary, to have your dentist file a pretreatment estimate for services totaling over $300 to fully identify what benefits are available to you. This will avoid any confusion as to the balance you may owe your dentist. Not all plans cover the same procedures, and if there is any doubt to the coverage of your plan a representative of Paramount Dental would be glad to go over it with you. Your dentist also has access to your specific coverage and can review it with you.

## Coinsurance

Covered Services and the percentage of covered expense provided by the Plan and limitations to covered services are indicated on Summary of Dental Plan Benefits. The percentage of plan payment (coinsurance) is valid only for services obtained from participating network Dentists contracted with Paramount Dental or a leased network. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as

"balance billing" and is not enforceable for Out-of-network Dentists as they are under no obligation to limit their fees.

# Plan Features

This list of plan features describes the features that are available through Paramount Dental but may not be included in the coverage that you or your employer has selected. To see a list of plan features that are specific to your benefit coverage, please refer directly to Summary of Dental Plan Benefits. If a plan feature is not listed on your Summary of Dental Plan Benefits then it is not a part of your Dental Benefit Plan.

### Plan Annual Maximum Benefits/Plan Year

Benefits payable under the Plan, regardless of whether coverage is continuous or not, shall be subject to the Plan Annual Maximum for each plan year. Payments under your Certificate for ALL Covered Services apply to the Plan Annual Maximum benefit excluding orthodontic services. Change of the dental plan coverage, termination, and reinstatement of coverage does not eliminate frequency limitations or Plan Annual Maximum benefit used.

Annual maximum benefits are based on a policy/benefit year unless otherwise noted on the Summary of Dental Plan Benefits beginning with the Plan's effective date of coverage,

After the Plan Annual Maximum Benefit is exhausted, you are responsible for all subsequent charges to your dentist.

### Lifetime Maximum Benefit – Orthodontics

If your plan includes orthodontics coverage, your Summary of Dental Benefits will list a lifetime maximum of orthodontic benefits per member. This is the cumulative dollar amount that will be paid for orthodontic dental care for the life of the Member.

### Deductible

The Plan Year Deductible (if any) is applicable to Covered Services incurred in each Plan Year. Your policy will determine the Deductible application method chosen by Your employer. The available methods include:

### Out of Pocket Deductible-

An out of pocket deductible is the specified & consistent amount reduced from the plan's covered expense which must be paid in full by the Member each plan year. It is applied chronologically according to the dates in which the Covered Services were completed and increases the patient responsibility by the specified amount until the earlier of two events 1) individual deductible is met, or 2) family deductible is satisfied.

Ex: (Fee Allowed X Co-Insurance) – Deductible = Plan Payment

Patient A receives major services covered at 50% under the plan. This patient is responsible for a $50 individual deductible.

### Benefit Deductible

A benefit deductible is the amount a Member must pay toward Covered Services before the carrier will reimburse for those Covered Services. This amount may vary based upon the co-insurance of the Covered Service.

Ex: (Fee Allowed – Deductible) X Co-Insurance = Plan Payment
Patient B receives major services covered at 50% under the plan. This patient is responsible for a $25 individual deductible.

### Waiting Period

The Waiting Period is the period of time beginning on the Member's Effective Date before benefits for certain Covered Service become eligible for reimbursement. Unless otherwise specified, the most recent effective date is utilized in the application of the Waiting Period, this includes a change to Your dental plan coverage such as termination and reinstatement of coverage.

### Alternate Benefits

There is often more than one service that can be used to appropriately treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. If applicable, the amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. A Member and his Dentist may decide on a more costly service or material than We have determined to be satisfactory for the treatment of the condition. In this case, the Plan will be a benefit toward the cost of the more expensive service or material, but the payment will be limited to the benefits payable for Covered Expenses for the least costly Covered Service.

### Unbundling

When charges for less complicated Services performed in conjunction with the more comprehensive/extensive definitive treatment are separated, these less complicated components may be considered as parts of the primary Service. If the Dentist bills separately for the primary Service and each of its component parts, the total benefit payable for all related charges will be limited to the benefits payable for Covered Expenses for the primary Service.

# Service Exclusions

Paramount Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Benefits. All charges for the same will be your responsibility (though your payment obligation may be

satisfied by insurance or some other arrangement for which you are eligible):

**General Exclusions**
All Master Group Policies and Certificates issued or administered by Paramount Dental are subject to the following General Exclusions.

This plan will not pay for:

1. Dental services that are not listed in the Plan Covered Services and Plan General Exclusions, Limitations and Restrictions attached to this Certificate.
2. Claims for dental services rendered before the Effective Date or after coverage is terminated.
3. Claims for dental services covered under non-dental insurance.
4. Claims for services performed primarily to rebuild occlusion or for full mouth reconstruction.
5. Claims for Enrollees until Paramount Dental receives the appropriate contracted payment(s) for Premiums.
6. Claims for services which are not completed.
7. For duplicates, lost, or stolen prostheses, appliances, and/or radiographic images.
8. A Claim must be received within one year from the date of service.
9. Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous (baby) teeth.
10. Orthodontic treatment, unless otherwise specified in your Summary of Dental Plan Benefits.
11. Treatment of temporomandibular joint or jaw joint disorder (TMJ).
12. Dental services provided by a non-network participating dentist to the extent that the charges exceed the amount payable for services under the nonparticipating dentist fee schedule.
13. Pediatric dental Essential Health Benefits (EHB) as mandated by the Affordable Care Act (ACA).
14. Dental services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
15. Dental services or charges separately billed by hospitals, laboratories, pharmacies or other institutions other than a dentist practice.
16. Experimental or investigational dental treatment.
17. Dental services as a result of your participation in a misdemeanor, felony, riot or insurrection.
18. Dental services charged and filed on a claim under an unspecified CDT service code X999.
19. Submitted claims for which Paramount Dental has not received the dentist documentation (federal W9 form, documentation requirements – radiographs, primary explanation of benefits, etc., or unable to process due to incorrect filing information) required to determine and finalize the claim benefit.

# Service Limitations

The benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Paramount Dental plan or, at the request of your group, any dental plan:

Diagnostic Evaluations and Treatments
Evaluations (examinations), including any and all procedure codes, are payable as stated in your Summary of Benefits. These include all examinations and evaluations performed by any general dentist or specialist.

A comprehensive oral evaluation or a comprehensive periodontal evaluation for a new or established patient is payable according to the time period specified in your Summary of Benefits. A comprehensive periodontal evaluation will only be payable for members that are age 14 and above.

Diagnostic Imaging, Tests, and Examinations
The maximum amount considered for all radiographic images (also referred to as X-rays) taken on one day will be equivalent to an allowance of a full mouth X-ray. The difference may not be billed to the Enrollee.

Panoramic (including image capture only) or full mouth X-rays are payable according to your Summary of Benefits. If a full mouth X-ray is performed within 12 months of any bitewing image(s), the allowable amount for the full mouth X-ray will be reduced by the charges for bitewing(s). Panoramic or full mouth X-rays will not be payable if performed within 12 months of a set of vertical bitewings images.

Periapical images (including image capture only) are payable up to a maximum of 3 during a 12-month period.

Occlusal images (including image capture only) are payable only once per arch per 12 months.

Vertical bitewings (including image capture only) are payable once per 12 months unless a complete series of images or four bitewings were paid in that same 12 months.

Bitewing radiographic images (including image capture only) are limited to the amount specified in your Summary of Benefits. Bitewings will not be payable if performed within 12 months of a complete series of images or a set of vertical bitewings images.

2D cephalometric images or 2D oral/facial photographic images (including image capture only) will be payable only if performed in conjunction with a Plan that covers orthodontic services and treatment. Cephalometric images are payable

every 2 years unless image captures only were paid during the same 2 years. 2D oral/facial images are payable every 5 years unless image captures only were paid during the same 5 years.

Pulp vitality tests are payable for one charge per date of service.

Diagnostic casts are payable once per 5 years and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Preventive Services:
Prophylaxis: A teeth cleaning (includes prophylaxis, periodontal scalings and root planning, periodontal full mouth debridement and periodontal maintenance) is payable according to the limitations listed in your Summary of Benefits., regardless of the dentist's specialty. A teeth cleaning for children under the age of 14 will be payable when filed as a child's cleaning.

Fluoride: A preventive fluoride treatment is payable as listed in your Summary of Benefits.

Sealants: Will be payable on permanent molar teeth (per tooth) as listed in your Summary of Benefits. A replacement for a sealant will not be payable for a period of 5 years. If a sealant was applied to a tooth, a restoration on the same tooth will not be payable for a period of 3 years.

Space Maintenance: Space maintainers are payable once every 3 years for children under 13 years of age The re-cementation or re-bonding of a space maintainer is payable only after 12 months after the initial placement and only once per 12 months.

Restorative Services:
A restoration/filling (amalgam or resin-based composite) is payable as listed in your Summary of Benefits. An additional restoration on the same tooth surface will not be payable for a 2-year period. A restoration will not be payable within 2 years of placing a crown on the same tooth or a sealant on the same surface within 2 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered for payment.

Crowns, or Inlays/Onlays (in any combination including implant supported) are payable as listed in your Summary of Benefits. A charge for a crown or an inlay/onlay on a tooth following the placement of an amalgam or resin-based composite restoration on the same tooth is not eligible for payment for a period of 2- years. Crowns, other than prefabricated steel crowns, are not payable for primary teeth. Composite/resin inlays must be laboratory processed.

A resin-based composite (indirect) crown is payable on anterior teeth only.

Individual crowns over implants are payable as listed in your Summary of Benefits.

Not all crowns or inlay/onlays procedure codes are considered covered if a corresponding procedure code using new and advanced materials is determined to be available.

Crowns, inlays/onlays may be subject to review for extensive loss of tooth structure due to caries (decay) or fracture to determine coverage. A pre-treatment estimate is recommended to determine coverage.

A recementation of an inlay, onlay, or crown is payable only once per 12 months and will not be considered for payment if within 12 months of the original cementation.

A protective restoration is payable once every 2 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for a subsequent definitive treatment are subject to an adjustment if performed within 12 months of a protective restoration.

A core buildup will not be payable if performed as specified in your Summary of Benefits. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed. A pre-treatment estimate is recommended to determine coverage.

A pin retention is payable per tooth and limited to posterior teeth only. Additional pins will be disallowed.

A post and core in addition to a crown is payable once per 5 years per tooth. A payment is not eligible if performed within 5 years of a core buildup or another post and core. Procedure is not payable without history of root canal therapy.

Endodontics:
A therapeutic pulpotomy is payable for primary teeth only and only once per tooth per lifetime. Charges are exclusive of the final restoration charge.

All pulpal and endodontic therapy and apexification/recalcification should be coded by the tooth receiving treatment, not the number of canals per tooth. A single periapical will be considered for payment with an endodontic therapy or an apexification/recalcification only (not pulpal). Separate fees for other radiographs and images are considered part of the treatment plan and will be

disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.

Pulpal therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Endodontic therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Apexification/recalcification is limited to children under 16 years of age and once per lifetime. Not eligible for payment for retreatment within 4 years of the date of the original treatment.

An apicoectomy is payable only once per lifetime.

A canal preparation and fitting of preformed dowel or post is payable once per 7 years. Charges will be disallowed if submitted in conjunction with a post and core, fabricated post, or prefabricated post/core.

Non-Surgical and Other Periodontal Services:
Periodontal maintenance is payable as listed in your Summary of Benefits. This procedure will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a scaling in the presence of gingival inflammation, or a full mouth debridement.

A scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable as listed in your Summary of Benefits. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling in the presence of gingival inflammation, a full mouth debridement or periodontal maintenance. The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Not payable on deciduous teeth. This procedure requires the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. Charges not meeting established criteria will be disallowed. A pretreatment estimate is recommended to determine coverage. Dental Review Team maintains discretionary authority regarding review requirements.

A scaling in presence of generalized moderate or severe gingival inflammation – full mouth is payable once every 5 years and only for enrollees over 15 years of age. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a full mouth debridement or periodontal maintenance.

A full mouth debridement is payable only for enrollees over 15 years of age. Procedure is payable once every 3 years and 3 years must lapse between any associated periodontal scalings (scaling and root planning and scaling in the presence of gingival inflammation) were performed. Will not be payable if performed within 6 months of or the same date of service as a prophylaxis, a scaling and root planning or a scaling in the presence of gingival inflammation, or periodontal maintenance.

Periodontic Surgical
The following services are payable only once per area treated within a 5-year period:

- Gingivectomy or gingivoplasty (four or more teeth/tooth per quadrant only)
- Clinical crown lengthening (per tooth)
- Osseous surgery
- Guided tissue regeneration (includes barrier and its removal, as necessary)

Two tissue grafts (of any type, including pedicle soft, autogenous connective, non-autogenous connective, and free soft) are payable once per area treated/quadrant every 5 years. Teeth #24-25 are considered one site.

Prosthodontics:
One upper and one lower denture (including complete, immediate, partial, immediate partial, overdenture and interim) are payable as listed in your Summary of Benefits. Charges for a conventional, removable partial dentures or a complete denture are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch or of any repairs, relines, rebases. Separate charges for diagnostic casts will be disallowed. An immediate denture will not be payable if used to replace a complete denture.

A repair to a complete or partial denture is payable once per 6 months only after 6 months has elapsed since the initial date of delivery of the appliance. A repair to a partial denture that replaces all teeth and acrylic on framework is payable once per 4 years only after 4 years has elapsed since the initial delivery of the appliance

A rebase or reline to a complete or partial denture is payable once per 4 years only after 6 months has elapsed since the initial date of deliver of the appliance.

Two tissue conditioning charges will be payable only within 6 months of delivery of immediate partial/denture only.

Fixed partial dentures, including partial denture pontics (non-resin), partial denture retainers (cast metal and porcelain/ceramic retainers only), and partial denture retainers-crowns (non-resin) are payable as listed in your Summary of Benefits. Charges are subject to the same definitions and restrictions as single restoration crowns. Each unit of a fixed partial denture must be

identified on the claim. Not eligible for pontics to replace third molars. All fixed prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 5 years of the original placement.

A re-cement or re-bond of a fixed partial denture is payable only once per 12 months per fixed partial denture and only after 12 months of the original cementation.

Oral Surgery:
Surgical extraction of an erupted tooth requiring removal on bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated, and the removal of residual tooth roots procedures include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed.

An exposure of an unerupted tooth or the placement of a device to facilitate the eruption of an impacted tooth will be payable only once per lifetime if the procedure is performed in conjunction with a Plan orthodontic covered services and treatment.

An incisional biopsy of soft oral tissue will be disallowed if performed in conjunction with an apicoectomy.

A transseptal fiberotomy/supra crestal fiberotomy is payable only on anterior permanent teeth and bicuspids and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Alveoplasty in conjunction with routine extractions are subject to review. Charges not meeting generally accepted standards of care will be disallowed.

Vestibuloplasty, ridge extension, procedures charges in conjunction with implant services will be disallowed.

Removal of torus mandibularis is payable only once per arch per lifetime.

Incision and drainage of abscess filed in conjunction with definitive treatment will be disallowed.

A frenectomy is payable once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed.

Excision of pericoronal gingiva filed in conjunction with definitive restorative treatment will be disallowed.

Implant Services
A surgical placement of an implant body (endosteal) or a mini implant is payable as listed in your Summary of Benefits. Allowance includes the treatment plan, local anesthetic and post-surgical care. Coverage is limited to enrollees over 15 years of age.

A prefabricated abutment or a custom fabricated abutment is payable once per 5 years per tooth site. Coverage is limited to enrollees over 15 years of age.

Single crowns and fixed partial denture retainers (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported single crowns and fixed partial dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Removable dentures and fixed dentures (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported removable dentures and fixed dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Adjunctive/Other Services Limitations
Palliative (emergency) treatments will be payable 2 per 12-month period. Charges filed in conjunction with definitive treatment will be disallowed.

Deep sedation/general anesthesia and intravenous moderate (conscious) sedation/analgesia will be payable up to a total of 30 minutes per date of service.

Inhalation of nitrous oxide/analgesia will be payable once per date of service.

An athletic mouth guard is payable once per 12 months.

Occlusal guards are payable once every 5 years. Charges to modify the appliance or for occlusal adjustment are not payable.

Teledentistry benefits are payable as specified in your Summary of Benefits.

# Disallowed Services

Participating Dentists may not charge eligible persons for disallowed services or supplies. All charges fromnon-participating dentists for the disallowed services areyour responsibility.

# How Payment Is Made

**In-Network Dentists**
In-Network Dentists are responsible for submitting claims to Paramount Dental on Your behalf for rendered services. Paramount Dental will reimburse the In-Network Dentist directly for Covered Services.

A Member is responsible for the Deductible and any out-of-pocket expenses required by the Plan including the co-insurance and the cost of services that are not covered by the Plan. It is possible that Your dentist's charges for one or more of the services may be higher than the maximum allowable under Your Paramount Dental. If so, an In-Network Dentist must reduce the charged amounts. If a Member is billed by an In-Network Dentist for a Covered Service (other than the Deductible, co- insurance, or amount above the maximum allowable fee), the Member should contact either the In-Network Dentist or Paramount Dental.

**Out-Of-Network Dentists**
If You visit an Out-Of-Network Dentist, you may be personally responsible for submitting claims directly to Paramount Dental. Some Out-Of-Network Dentist will file the claim as a courtesy to their patients, but they are under no obligation to do so. A Member must provide all of the information the Plan needs to process such claims, including an ADA approved claim form, an invoice of the charges and proof of payment. If a Member does not provide this information, a Member may not be paid or the payment will be distributed to the Out-Of-Network Dentist.

A Member is responsible for the Deductible, any out-of-pocket expenses required by the Plan including the coinsurance and the cost of services that are not covered by the Plan, and any charges above the maximum allowable for the service.

Your out-of-pocket expenses will most likely be higher by seeing an out-of-network dentist because your dentist can Balance Bill the amount that is not covered by Paramount Dental to you and you are responsible for all charges not covered by your Dental Plan.

**Filing a Claim**
Network Dentists are responsible for submitting claims to Paramount Dental on your behalf. Out-Of-Network Dentist may file the claim as a courtesy to their patients, but are under no obligation to do so. All claims should be submitted to the Paramount Dental address provided in a separate section of this document. The following information should be included on a standard ADA claim form:

1. Covered Employee's name, address, and identification number (SSN)
2. Patient's name, date of birth, and identification number (SSN)
3. Itemized bill including the ADA code, description of each charge, and date of service
4. Name and address of the Rendering Dentist
5. Rendering Dentist's Tax ID Number (W-9 Form)

Note: To be considered for payment, a claim must be submitted within 1 year from the date of service. Some services may require additional information, such as a radiograph image or a periodontal chart before being processed. Benefit payment can only be determined at the time that that claim is submitted with all required documentation. Reference the Plan General Exclusions, Limitations, and Restrictions, including provider supporting documentation provision for more information.

# Notice of Claim

We must receive written notice within sixty (60) days after a Claim starts or as soon as reasonably possible. Failure to give notice within that time will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give notice at that time, but such notice was given as soon as was reasonably possible. The notice shall be sent to Paramount Dental or given to Our agent. Notice given by or on behalf of the Member or the Member's beneficiary to Us or to any of our authorized agents with information sufficient to identify the Member is considered notice to Us. If You visit an Out-of-Network Dentist, You may personally be responsible for submitting Claims directly to Paramount Dental.

# Claim Forms

Your dentist will file Your claim or provide You with the forms necessary to file the claim. If Your dentist does not provide these forms within fifteen (15) days, You may send Us a written statement to satisfy this requirement. This statement should include enough information to identify You as well as the nature and extent of the Claim. It should be sent to Us within the time stated in the Proof of Loss provision.

Once Paramount Dental processes Your dental Claim, You will receive an Explanation of Benefits explaining payment amounts. It is possible that Your dentist's charges for one or more of the procedures may be higher than the maximum allowed under Your Paramount Dental. If so, a contracted Network Dentist must reduce the charged amounts. An Out-of-Network Dentist may charge You for the difference since they are not contractually liable to accept Your plan's fee schedule.

# Proof of Loss

We must receive written proof of loss within ninety (90) days of a Claim. If it is not possible for proof to be provided within

the ninety (90) days, We will not deny a Claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless You are legally incapacitated.

## Time of Payment of Claims

Benefits for loss covered by the Policy will be paid when Paramount Dental receives all information necessary, including premium payment, to correctly adjudicate the claim, but not more than thirty (30) days after receipt of all necessary information. Upon the Member's death, any payments outstanding will be paid, at our option, to the Member's beneficiary or to the Member's estate.

If We fail to pay or deny a clean claim in the time required, and We subsequently pay the claim, We will pay the provider that submitted the claim interest on the allowable amount of the claim.

## Legal Actions

A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

## Coordination of Benefits

Coordination of Benefits ("COB") applies to this plan when an eligible person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this plan's benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

**Terms:**

1. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    a. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

    b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, which is associated with a Covered Service for which reimbursement is available or for which reimbursement would be available but for the application of contractual limitations. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

4. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the plan year excluding any temporary visitation.

5. Benefit reserve is the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

**Order of Benefit Determination Rules:**

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
3. Each Plan determines its order of benefits using the first of the following rules that apply:

a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the [calendar] year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(2) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(3) For a Dependent Child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

f. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

### Effect on the Benefits of this Plan:
When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

### Right To Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Paramount Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Paramount Dental need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Paramount Dental any facts it needs to apply those rules and determine benefits payable.

### Facility of Payment
Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan or plans, Paramount Dental will have the right, exercisable alone and at its discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision. The amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments; Paramount Dental will be fully discharged from liability under the Plan. The benefits that are payable in accordance with this provision will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this provision.

## Right of Recovery
Whenever payments have been made in excess of the amount due under the Plan, the Paramount Dental shall have the right, exercisable alone and in its sole discretion, to recover such excess payments from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

## Termination of Coverage

Your dental coverage may be automatically terminated:
When Your employer advises Paramount Dental to terminate Your coverage;

When Your employer fails to pay timely Premium payments or fees to Paramount Dental; or

For any other reason stated in the Policy.

A person whose Eligibility is terminated may not continue coverage under their Employer's contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) or comparable, nonpreempted state law.

## Continuation of Coverage

Continuation Coverage Rights Under The Consolidated Omnibus Budget Reconciliation Act Of 1985 (COBRA)

### Introduction
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to an Enrolled Employee who would otherwise lose coverage under the Plan. It can also become available to Enrolled Dependents covered under the Plan when they would lose their coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the COBRA Procedures or contact the Plan Administrator. In the event that an individual receives a COBRA election form with incorrect plan information, the Plan will notify the individual of the accurate Plan terms. The election will be in accordance with the accurate Plan benefit, terms, and coverage.

### What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage will be offered to

each person who is a “Qualified Beneficiary.” The Enrolled Employee and each Enrolled Dependent could become Qualified Beneficiaries if coverage under the Certificate is lost because of the Qualifying Event. Under the Master Group Policy, Qualified Beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

An Enrolled Employee will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of either the following:

- Hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct by the Enrolled Employee.

An Enrolled Spouse will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of the following:

- The Enrolled Employee dies;
- The Enrolled Employee’s hours of employment are reduced;
- The Enrolled Employee’s employment ends for any reason other than his/her gross misconduct;
- The Enrolled Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The Enrolled Employee becomes divorced or legally separated from his/her Enrolled Spouse

An Enrolled Child will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of any of the following:

- The Enrolled Employee dies;
- The Enrolled Employee’s hours of employment are reduced;
- Employment of the Enrolled Employee ends for any reason other than his/her gross misconduct;
- The Enrolled Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The Enrolled Employee becomes divorced or legally separated from his/her spouse; or
- The Enrolled Child is no longer eligible for coverage under the Plan as a “Dependent Child.”

### When is COBRA Coverage Available?

The Master Group Policy will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

Enrolled Employee or Dependent must notify the Plan Administrator within 60 days after the Qualifying Event occurs.

### How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children who are Qualified Beneficiaries.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Enrolled Employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the divorce or legal separation of the Enrolled Employee, or an Enrolled Dependent losing eligibility for coverage under the Certificate as a Dependent Child, COBRA continuation coverage lasts up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Enrolled Employee’s hours of employment, and the Enrolled 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. 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.

Disability extension of 18-month period of continuation coverage. If an Enrolled Person covered under Your Certificate is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, each Enrolled Person may be entitled to receive up to an additional 11 months of COBRA continuation coverage (while the disability continues), for a total maximum of 29 months.

Second Qualifying Event extension of 18-month period of continuation coverage
If an Enrolled Person experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the Enrolled Spouse and Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator.

Questions concerning Your Certificate, the Master Group Policy or Your COBRA continuation coverage rights should be addressed to Your Plan Administrator or contacts identified below. 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) in Your area (EBSA Regional Office: Cincinnati Regional Office, 1885 Dixie Highway, Ste 210, Ft. Wright, KY 41011-2664, Tel 859.578.4680/Fax 859.578.4688) or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Change In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members.

## Questions and Assistance

Questions regarding your policy or coverage should be directed to:
Claims Department Paramount Dental.
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

## General Conditions and Additional Information

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan. No failure to enforce any provision of the Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

## Entire Contract & Changes

The Policy, including the endorsements, Certificates, Summary of Dental Plan Benefits, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy will be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by You or the Employer, in the absence of fraud, as a representation and not a warranty.

We may amend coverage, limitations to the Covered Services, General Exclusions, Annual Maximum, benefit payments or any other terms of this Certificate or the Master Group Policy upon thirty (30) days written notice to You and Your employer. This Certificate will pay for any Covered Services rendered prior to the Effective Date of the change. If there are any discrepancies as to coverage, limitations to Covered Services, General Exclusions, Annual Maximum or other provisions stated herein and as stated in the Master Group Policy, the provisions of the Master Group Policy will supersede those set forth herein.

## Claims Appeal Procedure

Informal Claims Appeal Procedure
Your Paramount Dental plan has been carefully designed to provide You with the maximum amount of covered benefits for Your level of payment/Premium. Since Paramount Dental is always looking for ways to make Our Master Group Policies and Certificates even better, Your suggestions are encouraged. Occasionally, even after You have reviewed the applicable sections of this Certificate pertaining to Your issue at hand, You may have a question. Your questions may involve dentists, Covered Services, the agents who sold and serviced Your Paramount Dental plan, policies, or procedures.

Paramount Dental always notifies You or Your authorized representative of a benefit determination after Your Claim is filed. This notice is made via an Explanation of Benefits (EOB). An adverse benefit determination is any denial, reduction or termination of the benefit for which You filed a Claim, or a failure to provide or to make payment (in whole or in part) of the benefit You sought. This includes a determination based on Eligibility, the administration of Covered Services, Limitations or restrictions, and payment amounts. If You receive notice of an adverse benefit determination, and if You think that Paramount Dental incorrectly denied all or part of Your Claim, You may take the following steps:

First, You or Your dentist should contact Paramount Dental's Member Services team and ask them to check the Claim to make sure it was correctly processed. If You contact Us in writing, please enclose a copy of Your Explanation of Benefits and describe the problem. Paramount Dental provides this opportunity for You to describe problems and submit information that might indicate that Your Claim was improperly denied and allow Paramount Dental to correct this error quickly.

Formal Claims Appeal Procedure
Whether or not You have contacted Paramount Dental informally, as described above, to recheck the initial determination of Your Claim, You or Your authorized representative may submit Your Claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of Your Claim, You must send Your request in writing to the Dental Claims Review Team at Paramount Dental.

You must include Your name and address, the Member's ID number, the reason You believe Your Claim was wrongly denied, and any other information You believe supports Your Claim, including sections of Certificate that support Your appeal. If You would like a record of Your request and proof that is was received by Paramount Dental, You should mail it certified mail, return receipt requested. You or Your authorized representative should seek a review as soon as possible after You receive Your EOB; however, You must file Your appeal within ninety (90) days of the date of which You receive Your notice of the adverse benefit determination You are asking Paramount Dental to review.

The Dental Claims Review Team will make their decision and notify You in writing within 30 days of receiving Your request. Their notice of any adverse determination will: (a) inform You of the specific reasons for the denial; (b) list the pertinent Master Group Policy/Certificate provision on which the denial is based; (c) contain a statement that You are entitled to receive upon request and at no cost, reasonable access to and copies of the documents, records and other information relevant to the decision to deny Your Claim; and (d) contain a statement that You may seek to have Your Claim re-evaluated by the appropriate Department of Insurance in Your state of domicile. You may also have the right to seek to have Your Claim paid by filing a civil action in court.

# Notice of Privacy Practices

In compliance with certain applicable laws, the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Paramount Dental has adopted these policies. Paramount Dental acknowledges participants' privacy rights as specified in these laws, and has adopted policies and procedures to ensure Your privacy rights are protected.

This Notice describes how nonpublic personal financial information (NPFI) and protected health information (PHI) about You may be used and disclosed and how You can access this information. In this Notice, We explain how We protect the privacy of Your NPFI and PHI, and how We will allow it to be used and given out (disclosed). We are required to provide You with a copy of this Notice of privacy practices upon request. We must follow the privacy practices described in this Notice while it is in effect.

Our Commitment Regarding Your Confidential Information:
We understand the importance of Your NPFI and PHI (hereafter known as Confidential Information), and follow strict policies (in accordance with state and federal privacy laws) to keep Your information private.

Our Privacy Principles:

- We do not sell customer Confidential Information.
- We do not provide customer Confidential Information to persons or organizations outside Paramount Dental and Our business associates for marketing purposes.
- We contractually require any person or organization providing products or services on Our behalf to protect the confidentiality of information We obtain from You.

We afford prospective and former customers the same protections as existing customers with the respect to the use of Confidential Information. Your privacy is a high priority for Us and it is treated with the highest degree of respect. We collect and use Confidential Information We believe is necessary to administer Our business and to provide You with customer service. We use Confidential Information to underwrite Your policies, process Your Claims, ensure proper billing, and service Your accounts. We share Confidential Information as necessary to handle Your Claims and to protect You against fraud and unauthorized transactions. However, We want to emphasize that We are committed to maintaining the privacy of this information in accordance with law. All individuals with access to Confidential Information about Our customers are required to follow this policy.

Confidential Information Collected:

- Confidential Information includes demographic data that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health, the provision of health care to You, or the payment for that care.
- Confidential Information includes Your name, address, date of birth, marital status, sex, social security number, dental information, and Enrollee information, including information about Your transactions with Us, such as Claim history and Premium payments.
- Information Disclosed:
- We may provide Confidential Information to You in order to supply You with information about Your Benefits, or if You request to inspect Your Confidential Information.
- We may provide Your Confidential Information to health care providers and to Our business associates who request Confidential Information for payment-related activities and for health care operations.
- We may provide Your Confidential Information to someone who has the legal right to act on Your behalf.
- We may provide Confidential Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.
- We may provide Confidential Information without Your written permission for matters in the public interest such as public health and safety activities or averting a serious threat to the health or safety of others.
- We may provide Confidential Information that We collect to third-parties involved in the underwriting, processing, servicing and marketing of Your Paramount Dental insurance products. We will not provide this information to any other third party for purposes other than set forth above unless We have a written agreement that requires such third party to protect the confidentiality of this information or Your written authorization.

- The law or the courts may require Us to provide Confidential Information to persons or agencies involved in regulatory, enforcement, or civil or criminal judicial activities.
- When We provide Your Confidential Information to any third party, We will provide only a limited data set, or if needed, the minimal amount of information that We deem is necessary.
- We do not disclose any Confidential Information about Our customers to anyone except as permitted or required by law.
- We must obtain Your written authorization for any disclosures of Your Confidential Information for purposes other than those listed above, including disclosures of psychotherapy notes or for marketing purposes.
- We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.

Security of Your Confidential Information:

- Access of Your Confidential Information is available from Us only to persons involved in underwriting, processing information, marketing company products, or providing dental care for Your benefit. Access must be granted to those entities to enable them to provide the excellent service You have come to expect from Paramount Dental.
- We maintain physical, electronic, and procedural safeguards that comply with state and federal standards to guard Your Confidential Information.
- If We become aware that an item of Confidential Information may be materially inaccurate, We will make a reasonable effort to confirm its accuracy and correct any error as appropriate.
- If We believe Your Confidential Information has been breached, You will receive a written notification of the suspected breach.

Individual Rights:

- You have a right to learn about the nature and substance of any Confidential Information Paramount Dental has in its files about You. We reserve the right to charge a reasonable cost-based fee for copying and postage.
- You have the right to an accounting of certain disclosures of Your Confidential Information.
- You have the right to request that We place restrictions on the way We use and disclose Your Confidential Information. We will inform You within thirty (30) days of Our decision concerning Your request. We will agree to any request to restrict the disclosure of Your Confidential Information if the disclosure is for carrying out payment or health care operations and You have paid the provider in full out of Your pocket.
- You have a right to inspect Your Confidential Information and request that We amend it in Our files.
- You have a right to obtain a copy of Your Confidential Information that We use or maintain in an electronic health record. We reserve the right to charge a reasonable cost-based fee to provide such information to You or Your specific designee.
- Individual Enrollees who believe that the way we communicate decisions related to payment and Benefits may endanger their Confidential Information may request that We communicate with them using a reasonable alternative means or location.

Duties:

- Paramount Dental is required to abide by the terms of this Notice, and reserves the right to change the terms of this Notice at any time, provided that applicable law permits such changes. These revised practices will apply to Your Confidential Information regardless of when it was created or received. Before We make a material change to Our privacy practices, We will provide You with a revised Notice of Privacy Practices.
- Where multiple state or federal laws protect the privacy of Your Confidential Information, We will follow the requirements that provide the greatest privacy protection.

Further information:

If You need more information about Our privacy policy, or are concerned that We may have violated Your privacy rights, please contact Paramount Dental's Privacy Officer.

You may also submit a written complaint to:
Attn: Region
V, Office of Civil Rights
U.S. Dept. of Health and Human Services 233 N.
Michigan Ave, Ste 240
Chicago, IL 60601
Voice mail: 312.866.2359
Fax: 313.866.1807

We support Your right to protect the privacy of Your Confidential Information. We will not take action against You.

## Physical Examinations and Autopsy

We reserve the right, at our own expense, to examine a Member when and as often as may be reasonably required for the determination of a claim. We may request an autopsy in case of death where it is not forbidden by law.

# ERISA

As a participant in a Paramount Dental plan, You may be entitled to certain rights and protections under ERISA. You should check with Your employer to determine whether ERISA applies in Your situation. If You are covered by ERISA, then You may:

- Obtain the Plan Administrator's name, address, and telephone number from Your employer.
- Examine (without charge) at the Plan Administrator's office and at certain other locations, all plan documents, including the group insurance contracts, and copies of all documents filed by the Plan Administrator with the Internal Revenue Service such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- Receive a Summary Annual Report (SAR), Summary Plan Description (SPD) and a Summary of Material Modifications (SMM).
- Receive a written explanation if Your Claim for Benefits has been denied. You have the right to request a review of any such denial. If Your Claim is still denied, You may sue for Your Benefits.
- File suit in Federal court if materials You requested aren't received within thirty (30) days (unless the materials weren't sent because of matters beyond the administrator's control), or if You feel Benefits have been improperly denied, or if You have been discriminated against exercising Your rights under ERISA. If You are successful, the court may require the administrator to provide the materials You requested and pay up to $110 a day until You receive them. The court will decide who should pay the 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 frivolous.

First, consult Paramount Dental or Your employer to be certain You thoroughly understand the dental Benefits coverage and Claims procedures. If, after following all procedures, satisfactory resolution has not been reached, You may wish to contact the appropriate state department of Insurance or the United States Department of Labor for assistance. Your exercise of any rights under ERISA will not adversely affect Your employment status or plan benefits.

# Grace Period

A grace period of thirty-one (31) days will be allowed for the payment of each Premium due after the first Premium. This coverage will remain in effect during the grace period unless the Employer has given advance written notice of discontinuance of coverage.

# Notification to Insureds

Paramount Dental will notify the Employer in writing by mail to the Employer's last known address at least thirty (30) days prior to the Effective Date of the termination of Your insurance, a change in Your Premium, a change in Eligibility or a change in Your Benefits. This notice will also be provided to You, the agent, and the Plan Administrator, if any.

# Misstatement of Age

If the age of any individual covered under the Policy has been misstated, all amounts payable under this policy shall be such as the Premium paid would have purchased at the correct age.

# Incontestability

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

# Conformity with State Statutes

If any provisions of the Plan is contrary to any law to which it is subject, such provision will be amended to conform to the minimum extent necessary to satisfy legal requirements.
**Questions regarding your policy or coverage should be directed to:**

Paramount Dental
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

If You (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: 1-800-622-4461 / (317) 232-239
Complaints can be filed electronically at www.in.gov/idoi.

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D0120 | PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT | 100/100 |
| D0140 | LIMITED ORAL EVALUATION-PROBLEM FOCUSED | 100/100 |
| D0145 | ORAL EVALUATION FOR A PATIENT UNDER 3 YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER | 100/100 |
| D0150 | COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT | 100/100 |
| D0160 | DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT | 100/100 |
| D0170 | RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT NOT POST-OPERATIVE VISIT) | 100/100 |
| D0180 | COMPREHENSIVE PERIODONTAL EVALUATION-NEW OR ESTABLISHED PATIENT | 100/100 |
| D0210 | INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES | 100/100 |
| D0220 | INTRAORAL-PERIAPICAL FIRST RADIOGRAPHIC IMAGE | 100/100 |
| D0230 | INTRAORAL-PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE | 100/100 |
| D0240 | INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE | 100/100 |
| D0270 | BITEWING-SINGLE RADIOGRAPHIC IMAGE | 100/100 |
| D0272 | BITEWINGS-TWO RADIOGRAPHIC IMAGES | 100/100 |
| D0273 | BITEWINGS-THREE RADIOGRAPHIC IMAGES | 100/100 |
| D0274 | BITEWINGS-FOUR RADIOGRAPHIC IMAGES | 100/100 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D0277 | VERTICAL BITEWINGS-7 TO 8 RADIOGRAPHIC IMAGES | 100/100 |
| D0320 | TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION | 100/100 |
| D0321 | OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES BY REPORT | 100/100 |
| D0330 | PANORAMIC RADIOGRAPHIC IMAGE | 100/100 |
| D0340 | 2D CEPHALOMETRIC RADIOGRAPHIC IMAGE ACQUISITION, MEASUREMENT AND ANALYSIS | 100/100 |
| D0350 | 2D ORAL/FACIAL PHOTOGRAPHIC IMAGES OBTAINED INTRAORALLY OR EXTRAORALLY | 100/100 |
| D0460 | PULP VITALITY TESTS | 100/100 |
| D0470 | DIAGNOSTIC CASTS | 100/100 |
| D0701 | PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0702 | 2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0703 | 2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY – IMAGE CAPTURE ONLY | 100/100 |
| D0706 | INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0707 | INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0708 | INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY | 100/100 |
| D0709 | INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY | 100/100 |
| D1110 | PROPHYLAXIS-ADULT | 100/100 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D1120 | PROPHYLAXIS-CHILD | 100/100 |
| D1206 | TOPICAL APPLICATION OF FLUORIDE VARNISH | 100/100 |
| D1208 | TOPICAL APPLICATION OF FLUORIDE- EXCLUDING VARNISH | 100/100 |
| D1351 | SEALANT-PER TOOTH (PERMANENT MOLAR TEETH) | 100/100 |
| D1510 | SPACE MAINTAINER-FIXED, UNILATERAL - PER QUADRANT | 100/100 |
| D1516 | SPACE MAINTAINER-FIXED-BILATERAL,MAXILLARY | 100/100 |
| D1517 | SPACE MAINTAINER-FIXED-BILATERAL,MANDIBULAR | 100/100 |
| D1520 | SPACE MAINTAINER - REMOVABLE - UNILATERAL - PER QUADRANT | 100/100 |
| D1526 | SPACE MAINTAINER-REMOVABLE-BILATERAL,MAXILLARY | 100/100 |
| D1527 | SPACE MAINTAINER-REMOVABLE-BILATERAL,MANDIBULAR | 100/100 |
| D1551 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY | 100/100 |
| D1552 | RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR | 100/100 |
| D1553 | RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT | 100/100 |
| D1575 | DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT | 100/100 |
| D2140 | AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT | 50/50 |
| D2150 | AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D2160 | AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT | 50/50 |
| D2161 | AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT | 50/50 |
| D2330 | RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR | 50/50 |
| D2331 | RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR | 50/50 |
| D2332 | RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR | 50/50 |
| D2335 | RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES (ANTERIOR) | 50/50 |
| D2390 | RESIN-BASED COMPOSITE CROWN, ANTERIOR (PRIMARY ONLY) | 50/50 |
| D2391 | RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR | 50/50 |
| D2392 | RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR | 50/50 |
| D2393 | RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR | 50/50 |
| D2394 | RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR | 50/50 |
| D2520 | INLAY-METALLIC-TWO SURFACES | 50/50 |
| D2530 | INLAY-METALLIC-THREE OR MORE SURFACES | 50/50 |
| D2542 | ONLAY-METALLIC-TWO SURFACES | 50/50 |
| D2543 | ONLAY-METALLIC-THREE SURFACES | 50/50 |
| D2544 | ONLAY-METALLIC-FOUR OR MORE SURFACES | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D2610 | INLAY-PORCELAIN/CERAMIC-ONE SURFACE | 50/50 |
| D2620 | INLAY-PORCELAIN/CERAMIC-TWO SURFACES | 50/50 |
| D2630 | INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES | 50/50 |
| D2642 | ONLAY-PORCELAIN/CERAMIC-TWO SURFACES | 50/50 |
| D2643 | ONLAY-PORCELAIN/CERAMIC-THREE SURFACES | 50/50 |
| D2644 | ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES | 50/50 |
| D2651 | INLAY-RESIN-BASED COMPOSITE-TWO SURFACES | 50/50 |
| D2652 | INLAY-RESIN-BASED COMPOSITE-THREE OR MORE SURFACES | 50/50 |
| D2663 | ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES | 50/50 |
| D2664 | ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES | 50/50 |
| D2710 | CROWN-RESIN-BASED COMPOSITE (INDIRECT) | 50/50 |
| D2740 | CROWN-PORCELAIN/CERAMIC SUBSTRATE | 50/50 |
| D2750 | CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL | 50/50 |
| D2751 | CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50/50 |
| D2752 | CROWN-PORCELAIN FUSED TO NOBLE METAL | 50/50 |
| D2753 | CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D2780 | CROWN-3/4 CAST HIGH NOBLE METAL | 50/50 |
| D2781 | CROWN-3/4 CAST PREDOMINANTLY BASE METAL | 50/50 |
| D2782 | CROWN-3/4 CAST NOBLE METAL | 50/50 |
| D2783 | CROWN-3/4 PORCELAIN/CERAMIC | 50/50 |
| D2790 | CROWN-FULL CAST HIGH NOBLE METAL | 50/50 |
| D2791 | CROWN-FULL CAST PREDOMINANTLY BASE METAL | 50/50 |
| D2792 | CROWN-FULL CAST NOBLE METAL | 50/50 |
| D2794 | CROWN-TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D2910 | RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION | 50/50 |
| D2920 | RE-CEMENT OR RE-BOND CROWN | 50/50 |
| D2930 | PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH | 50/50 |
| D2931 | PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH | 50/50 |
| D2933 | PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW (PRIMARY TOOTH) | 50/50 |
| D2934 | PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN-PRIMARY TOOTH | 50/50 |
| D2940 | PROTECTIVE RESTORATION | 50/50 |
| D2950 | CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D2951 | PIN RETENTION, PER TOOTH, IN ADDITION TO RESTORATION | 50/50 |
| D2952 | POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED | 50/50 |
| D2954 | PREFABRICATED POST AND CORE IN ADDITION TO CROWN | 50/50 |
| D2960 | LABIAL VENEER (RESIN LAMINATE) – DIRECT | 50/50 |
| D2962 | LABIAL VENEER (PORCELAIN LAMINATE) – INDIRECT | 50/50 |
| D2971 | ADDITIONAL PROCEDURES TO CUSTOMIZE A CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK | 50/50 |
| D2975 | COPING | 50/50 |
| D3220 | THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)-REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT | 50/50 |
| D3230 | PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3240 | PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3310 | ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3320 | ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3330 | ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION) | 50/50 |
| D3351 | APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC) | 50/50 |
| D3352 | APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC) | 50/50 |
| D3353 | APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D3410 | APICOECTOMY-ANTERIOR | 50/50 |
| D3421 | APICOECTOMY-BICUSPID (FIRST ROOT) | 50/50 |
| D3425 | APICOECTOMY - MOLAR (FIRST ROOT) | 50/50 |
| D3426 | APICOECTOMY (EACH ADDITIONAL ROOT) | 50/50 |
| D3430 | RETROGRADE FILLING-PER ROOT | 50/50 |
| D3450 | ROOT AMPUTATION-PER ROOT | 50/50 |
| D3920 | HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY | 50/50 |
| D3950 | CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST | 50/50 |
| D4210 | GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 50/50 |
| D4249 | CLINICAL CROWN LENGTHENING-HARD TISSUE | 50/50 |
| D4260 | OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 50/50 |
| D4261 | OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT | 50/50 |
| D4266 | GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE | 50/50 |
| D4267 | GUIDED TISSUE REGENERATION, NATURAL TEETH – NON-RESORBABLE BARRIER, PER SITE | 50/50 |
| D4270 | PEDICLE SOFT TISSUE GRAFT PROCEDURE | 50/50 |
| D4273 | AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D4274 | DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA) | 50/50 |
| D4275 | NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT | 50/50 |
| D4277 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT | 50/50 |
| D4278 | FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE | 50/50 |
| D4283 | AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE | 50/50 |
| D4285 | NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT SURGICAL SITE AND DONOR MATERIAL)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE | 50/50 |
| D4341 | PERIODONTAL SCALING AND ROOT PLANING-FOUR OR MORE TEETH PER QUADRANT (4 TEETH WITH 4+MM POCKETS) | 50/50 |
| D4342 | PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT | 50/50 |
| D4346 | SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION | 50/50 |
| D4355 | FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT | 50/50 |
| D4910 | PERIODONTAL MAINTENANCE | 50/50 |
| D5110 | COMPLETE DENTURE-MAXILLARY | 50/50 |
| D5120 | COMPLETE DENTURE-MANDIBULAR | 50/50 |
| D5130 | IMMEDIATE DENTURE-MAXILLARY | 50/50 |
| D5140 | IMMEDIATE DENTURE-MANDIBULAR | 50/50 |
| D5211 | MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D5212 | MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH) | 50/50 |
| D5213 | MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5214 | MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5221 | IMMEDIATE MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5222 | IMMEDIATE MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5223 | IMMEDIATE MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5224 | IMMEDIATE MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH) | 50/50 |
| D5225 | MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) | 50/50 |
| D5226 | MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH) | 50/50 |
| D5511 | REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR | 50/50 |
| D5512 | REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY | 50/50 |
| D5520 | REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH) | 50/50 |
| D5611 | REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR | 50/50 |
| D5612 | REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY | 50/50 |
| D5621 | REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR | 50/50 |
| D5622 | REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D5630 | REPAIR OR REPLACE BROKEN CLASP-PER TOOTH | 50/50 |
| D5640 | REPLACE BROKEN TEETH-PER TOOTH | 50/50 |
| D5650 | ADD TOOTH TO EXISTING PARTIAL DENTURE | 50/50 |
| D5660 | ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH | 50/50 |
| D5670 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY) | 50/50 |
| D5671 | REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR) | 50/50 |
| D5710 | REBASE COMPLETE MAXILLARY DENTURE | 50/50 |
| D5711 | REBASE COMPLETE MANDIBULAR DENTURE | 50/50 |
| D5720 | REBASE MAXILLARY PARTIAL DENTURE | 50/50 |
| D5721 | REBASE MANDIBULAR PARTIAL DENTURE | 50/50 |
| D5730 | RELINE COMPLETE MAXILLARY DENTURE (DIRECT) | 50/50 |
| D5731 | RELINE COMPLETE MANDIBULAR DENTURE (DIRECT) | 50/50 |
| D5740 | RELINE MAXILLARY PARTIAL DENTURE (DIRECT) | 50/50 |
| D5741 | RELINE MANDIBULAR PARTIAL DENTURE (DIRECT) | 50/50 |
| D5750 | RELINE COMPLETE MAXILLARY DENTURE (INDIRECT) | 50/50 |
| D5751 | RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D5760 | RELINE MAXILLARY PARTIAL DENTURE (INDIRECT) | 50/50 |
| D5761 | RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT) | 50/50 |
| D5820 | INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY | 50/50 |
| D5821 | INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR | 50/50 |
| D5850 | TISSUE CONDITIONING, MAXILLARY | 50/50 |
| D5851 | TISSUE CONDITIONING, MANDIBULAR | 50/50 |
| D5863 | OVERDENTURE-COMPLETE MAXILLARY | 50/50 |
| D5864 | OVERDENTURE-PARTIAL MAXILLARY | 50/50 |
| D5865 | OVERDENTURE-COMPLETE MANDIBULAR | 50/50 |
| D5866 | OVERDENTURE-PARTIAL MANDIBULAR | 50/50 |
| D6058 | ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN | 50/50 |
| D6059 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL) | 50/50 |
| D6060 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL) | 50/50 |
| D6061 | ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL) | 50/50 |
| D6062 | ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL) | 50/50 |
| D6063 | ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D6064 | ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL) | 50/50 |
| D6065 | IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN | 50/50 |
| D6066 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS | 50/50 |
| D6067 | IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS | 50/50 |
| D6068 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD | 50/50 |
| D6069 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL) | 50/50 |
| D6070 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL) | 50/50 |
| D6071 | ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL) | 50/50 |
| D6072 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL) | 50/50 |
| D6073 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL) | 50/50 |
| D6074 | ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL) | 50/50 |
| D6075 | IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD | 50/50 |
| D6076 | IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS | 50/50 |
| D6077 | IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS | 50/50 |
| D6082 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS | 50/50 |
| D6083 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D6084 | IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6086 | IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS | 50/50 |
| D6087 | IMPLANT SUPPORTED CROWN - NOBLE ALLOYS | 50/50 |
| D6088 | IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6092 | RE-CEMENT RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN | 50/50 |
| D6094 | ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6097 | ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6098 | IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS | 50/50 |
| D6099 | IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS | 50/50 |
| D6110 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MAXILLARY | 50/50 |
| D6111 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MANDIBULAR | 50/50 |
| D6112 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY | 50/50 |
| D6113 | IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR | 50/50 |
| D6114 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MAXILLARY | 50/50 |
| D6115 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MANDIBULAR | 50/50 |
| D6116 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D6117 | IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR | 50/50 |
| D6120 | IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6194 | ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6195 | ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6210 | PONTIC-CAST HIGH NOBLE METAL | 50/50 |
| D6211 | PONTIC-CAST PREDOMINANTLY BASE METAL | 50/50 |
| D6212 | PONTIC-CAST NOBLE METAL | 50/50 |
| D6214 | PONTIC-TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6240 | PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL | 50/50 |
| D6241 | PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50/50 |
| D6242 | PONTIC-PORCELAIN FUSED TO NOBLE METAL | 50/50 |
| D6243 | PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6245 | PONTIC-PORCELAIN/CERAMIC | 50/50 |
| D6545 | RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS | 50/50 |
| D6548 | RETAINER-PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS | 50/50 |
| D6740 | RETAINER CROWN - PORCELAIN/CERAMIC | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D6750 | RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL | 50/50 |
| D6751 | RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL | 50/50 |
| D6752 | RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL | 50/50 |
| D6753 | RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6780 | RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL | 50/50 |
| D6781 | RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL | 50/50 |
| D6782 | RETAINER CROWN - 3/4 CAST NOBLE METAL | 50/50 |
| D6783 | RETAINER CROWN - 3/4 PORCELAIN/CERAMIC | 50/50 |
| D6784 | RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6790 | RETAINER CROWN - FULL CAST HIGH NOBLE METAL | 50/50 |
| D6791 | RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL | 50/50 |
| D6792 | RETAINER CROWN - FULL CAST NOBLE METAL | 50/50 |
| D6794 | RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS | 50/50 |
| D6930 | RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE | 50/50 |
| D6940 | STRESS BREAKER | 50/50 |
| D7111 | EXTRACTION, CORONAL REMNANTS-DECIDUOUS TOOTH | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D7140 | EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL) | 50/50 |
| D7210 | SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED | 50/50 |
| D7220 | REMOVAL OF IMPACTED TOOTH-SOFT TISSUE | 50/50 |
| D7230 | REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY | 50/50 |
| D7240 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY | 50/50 |
| D7241 | REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS | 50/50 |
| D7250 | SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE) | 50/50 |
| D7251 | CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY | 50/50 |
| D7270 | TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH | 50/50 |
| D7280 | SURGICAL ACCESS OF AN UNERUPTED TOOTH | 50/50 |
| D7283 | PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH | 50/50 |
| D7284 | EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS | 50/50 |
| D7286 | INCISIONAL BIOPSY OF ORAL TISSUE-SOFT | 50/50 |
| D7291 | TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT | 50/50 |
| D7310 | ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT | 50/50 |
| D7311 | ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D7320 | ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT | 50/50 |
| D7321 | ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT | 50/50 |
| D7340 | VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION) | 50/50 |
| D7350 | VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE) | 50/50 |
| D7410 | EXCISION OF BENIGN LESION UP TO 1.25 CM | 50/50 |
| D7411 | EXCISION OF BENIGN LESION GREATER THAN 1.25 CM | 50/50 |
| D7450 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM | 50/50 |
| D7451 | REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM | 50/50 |
| D7471 | REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE) | 50/50 |
| D7472 | REMOVAL OF TORUS PALATINUS | 50/50 |
| D7473 | REMOVAL OF TORUS MANDIBULARIS | 50/50 |
| D7510 | INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE | 50/50 |
| D7511 | INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES) | 50/50 |
| D7830 | MANIPULATION UNDER ANESTHESIA | 50/50 |
| D7922 | PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN THE HEMOSTASIS OR CLOT STABILIZATION, PER SITE | 50/50 |
| D7961 | BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY) | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D7962 | LINGUAL FRENECTOMY (FRENULECTOMY) | 50/50 |
| D7970 | EXCISION OF HYPERPLASTIC TISSUE-PER ARCH | 50/50 |
| D7971 | EXCISION OF PERICORONAL GINGIVA | 50/50 |
| D7980 | SIALOLITHOTOMY | 50/50 |
| D8010 | LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION | 50/50 |
| D8020 | LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION | 50/50 |
| D8030 | LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION | 50/50 |
| D8040 | LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION | 50/50 |
| D8070 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION | 50/50 |
| D8080 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION | 50/50 |
| D8090 | COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION | 50/50 |
| D8210 | REMOVABLE APPLIANCE THERAPY | 50/50 |
| D8220 | FIXED APPLIANCE THERAPY | 50/50 |
| D9110 | PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT | 50/50 |
| D9222 | DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES | 50/50 |
| D9223 | DEEP SEDATION/GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT | 50/50 |

# Benefit Details

| ADA Code | Service Description | In/Out % |
|---|---|---|
| D9230 | INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS (PER VISIT) | 50/50 |
| D9239 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES | 50/50 |
| D9243 | INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT | 50/50 |
| D9944 | OCCLUSAL GUARD-HARD APPLIANCE, FULL ARCH | 50/50 |
| D9945 | OCCUSAL GUARD-SOFT APPLIANCE, FULL MOUTH | 50/50 |
| D9946 | OCCLUSAL GUARD-HARD APPLIANCE,PARTIAL ARCH | 50/50 |
| D9973 | EXTERNAL BLEACHING-PER TOOTH | 50/50 |
| D9974 | INTERNAL BLEACHING-PER TOOTH | 50/50 |
| D9995 | TELEDENTISTRY – SYNCHRONOUS - REAL-TIME ENCOUNTER | 100/100 |

# Plan General Exclusions, Limitations and Restrictions

Including provider supporting documentation requirements.

Eligibility is determined by the last date(s) of service and not based on a calendar or plan year. The last date(s) of service are determined by the prior completion date(s) in which the enrollee was eligible to receive benefits. Covered services for which a patient is not eligible, may be billed to the patient. Covered services that are disallowed by the plan, may not be billed to the patient.

| ADA Range | Limitations/Exclusions |
|---|---|
| D0120, D0145, D0160, D0170 | Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0140 | An evaluation limited to a specific oral health problem or complaint. The use of this procedure code is also appropriate in dental emergencies, trauma, acute infection, etc. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0150, D0180 | Eligible only once every 4 years. D0180 applies to age 14 and above. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period. |
| D0210, D0709 | A complete series includes bitewings. Eligible only once per 4 years. Not eligible if performed within 4 years of D0330, D0701 or D0709. If D0210 is performed within 12 months of D0270, D0272, D0273, D0274, D0708 the allowable amount for D0210 will be reduced by the charges for D0270, D0272, D0273, D0274, D0708. Not eligible if performed within 12 months of D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0220, D0230, D0707 | Eligible for a maximum of 3 during a 12 month period. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0240 | Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0706. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0270, D0708 | "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210, D0277 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D0272, D0273 | Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. |
| D0274 | "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. |
| D0277 | Not eligible if performed within 12 months of D0210 or D0274. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0320, D0321 | Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0330, D0701 | Eligible only once per 4 years. Not eligible if performed within 4 years of D0210, D0701 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D0340 | Eligible only once per 2 years. Not eligible if performed within 2 years of D0702. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D0350, D0703 | Eligible only once per 5 years. Not eligible if performed within 4 years of D0703. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D0460 | Eligible for one charge per date of service. |
| D0470 | Eligible only once per 5 years. It is included in the charges for complete or partial dentures, separate charges are disallowed. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D0702 | Eligible only once per 2 years. Not eligible if performed within 2 years of D0340. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D0706 | Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0240. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. |
| D1110, D1120 | Not eligible for more than 2 cleanings per 12 consecutive month period which includes utilization of codes D4341, D4346, D4355, or D4910. Reimbursement for D1120 is limited to enrollees under the age of 14. |
| D1206 | Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Eligible only for children under 14 years of age. |
| D1208 | Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Age limitation may apply. |
| D1351 | Eligible on permanent molar teeth (per tooth) only. Not eligible for replacement for a period of 5 years. Eligible only for children under 15 years of age. Not eligible for a restoration on the O, OB, or OL surfaces following the placement of a sealant on that surface or if a restoration involving the O surfaces has been performed for a period of 3 years. |
| D1510, D1516, D1517, D1520, D1526, D1527, D1575 | Eligible only for children under 13 years of age. Not eligible if performed within 3 years of D1510, D1515, D1520, D1525, or D1575. |
| D1551, D1552, D1553 | Not eligible within 12 months of the initial placement of the space maintainer. Eligible once per 12 months. |
| D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394 | Not eligible for the replacement of or an additional restoration on the same surface for a period of 2 years. Not eligible if performed within 3 years of placing a crown on the same tooth or a sealant on the same surface within 3 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2651, D2652, D2663, D2664, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794 | Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed. |
| D2710 | Eligible on anterior teeth only. Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed. |
| D2910, D2920, D6092 | Not eligible for the recementation of an inlay, onlay, or crown within 12 months of the original cementation. Eligible once per 12 months. |
| D2930, D2931, D2933, D2934 | Charges are subject to the same restrictions and conditions as D2520 through D2794. |
| D2940 | Not eligible for replacement by another protective restoration for a period of 3 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for definitive treatment are subject to an adjustment if performed within 12 months of D2940. |
| D2950 | Not eligible within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for core buildups requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed. |
| D2951 | Charge is per tooth and limited to posterior teeth only. Additional pins will be disallowed. |
| D2952, D2954 | Not eligible if performed within 7 years of D2950, D2952, or D2954. Eligible once per 7 years per tooth. Not allowable without history of root canal therapy. |
| D2960 | Not eligible for a replacement for 3 years. Placement is restricted to anterior permanent teeth only. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D2962 | Not eligible for a replacement for 7 years. Placement is restricted to anterior permanent teeth only. Charges for veneered crowns replacing labial veneers (porcelain) are not allowable for 7 years. |
| D3220 | Eligible for primary teeth only and only once per tooth. Charges are exclusive of the final restoration charge. |
| D3230 | Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3240 | Eligible on primary posterior teeth only. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3310, D3320, D3330 | Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3351, D3352, D3353 | Limited to children under 16 years of age. Eligible once per lifetime. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment. |
| D3410, D3421, D3425, D3426, D3430, D3450, D3920 | Eligible once per lifetime. |
| D3950 | Eligible once per 7 years. Charges will be disallowed if submitted in conjunction with D2952, D2953, D2954, or D2957. |
| D4210, D4260, D4261 | Eligible only once per area treated for a 5 year period. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D4249 | Eligible only once on a per tooth basis. Eligible only once per tooth per lifetime. |
| D4266, D4267 | Charges include the charge for the barrier, and its removal, if necessary. Eligible only once per area treated for a 5 year period. |
| D4270, D4273, D4275, D4277, D4278 | Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. Eligible only once per area treated for a 5 year period. |
| D4274 | Eligible only when this procedure is performed in an edentulous area adjacent to a periodontally involved tooth. The tooth and proximal area must be identified. Eligible only if no additional surgery is performed in the immediate area, eligible every 5 years. Eligible only once per area treated for a 5 year period. |
| D4283, D4285 | Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. |
| D4341 | Eligible per quadrant (4 or more active periodontal diseased and qualified teeth). The enrollee must exhibit pocket depths of at least 4 mm around at least 4 teeth in each quadrant to qualify for coverage for this procedure. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements. |
| D4342 | Eligible per quadrant (1 to 3 active periodontal diseased and qualified teeth). The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements. |
| D4346 | Eligible only for enrollees over 15 years of age. Eligible once per 5 years. Not eligible within 6 months of or same date of service as D1110, D1120, D4341/D4342 (quadrant allottment may apply), D4355, or D4910. |
| D4355 | Eligible only for enrollees over 15 years of age. To be eligible, procedure must be performed before and not on the same date of service as D1110, D4341, D4342, D4346, or D4910, or more than 3 years has lapsed since D1110, D4341, D4342, D4346, D4355, or D4910 was performed. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D4910 | Not eligible if performed within 6 months of or same date of service as D1110, D1120, D4341/D4342 if four quadrants were treated, D4346 or D4355. Not eligible for more than 2 per 12 consecutive month period. Eligible only for enrollees over 15 years of age. |
| D5110, D5120 | Not eligible for the replacement of a denture, including an immediate or partial denture, within 7 years. Separate charges for diagnostic casts (D0470) are disallowed. Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch or of any repairs, relines, rebases (D5510 through D5761). |
| D5130, D5140 | An immediate denture cannot be used to replace a complete denture. Other restrictions are the same as D5110 & D5120. |
| D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226 | Eligible every 7 years and are subject to the same conditions and restrictions listed for D5110 & D5120. Separate charges for diagnostic casts (D0470) are disallowed. The teeth replaced by the appliance must be identified on the claim form. |
| D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660 | Not eligible if the procedure is performed within 6 months of the date of delivery of the appliance. Eligible once per procedure code per 6 months. |
| D5670, D5671 | Eligible only once per 4 years per prosthesis. Not eligible if performed within 4 years of D5213 or D5214. Not eligible for charges for rebase, reline or repairs for 6 months. |
| D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761 | Not eligible within 6 months of the date of delivery of the appliance except when an immediate partial/denture is performed. Eligible for any of these procedures only once per 4 years per prosthesis. |
| D5820, D5821 | Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch. |
| D5850, D5851 | Eligible for two tissue conditioning charges within 6 months of delivery of immediate partial/denture only. |

| ADA Range | Limitations/Exclusions |
|---|---|
| D5863, D5864, D5865, D5866 | Charges are subject to the conditions listed for D5110/D5120 and D5213/D5214. |
| D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6194, D6195 | Charges are subject to the same definitions and restrictions listed for D2710 thru D2794 and D6210 thru D6974. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. |
| D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117 | Charges are subject to the same definitions and restrictions listed for D5110 thru D5866. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. |
| D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6545, D6548, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794 | Charges are subject to the same definitions and restrictions listed for D2520 thru D2794. Each unit of a fixed partial denture must be identified on the claim. Not eligible for pontics to replace third molars. All fix prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 7 years of the original placement. |
| D6930 | Not eligible within 12 months of the original cementation. Eligible only once per 12 months per fixed partial denture. |
| D7210, D7250 | Surgical extractions: use when either (1) removal of bone and/or (2) sectioning of tooth, including elevation of mucoperiosteal flap if indicated, is necessary. Surgical extraction charges include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed. |
| D7280, D7283 | Eligible once per lifetime. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |
| D7284, D7286 | Charges will be disallowed in performed in conjunction with D3410, D3421, D3425, D3426, or D3427. |
| D7291 | Eligible on anterior permanent teeth and bicuspids. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment. |

| ADA Range | Limitations/Exclusions |
| --- | --- |
| D7310, D7311 | Charges are subject to review if performed in conjunction with D7210 thru D7250. Charges not meeting generally accepted standards of care will be disallowed (see D7210 thru D7250). |
| D7340, D7350 | Charges filed in conjunction with implant services will be disallowed. |
| D7473 | Eligible once per arch per lifetime. |
| D7510 | Charges filed in conjunction with definitive treatment will be disallowed. |
| D7922 | Not eligible for more than a combination of two D7922 or D9110 per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed. |
| D7961, D7962 | Eligible once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed. |
| D7971 | Charges filed in conjunction with definitive restorative treatment will be disallowed. |
| D9110 | Not eligible for more than two palliative (emergency) treatments per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed. |
| D9222, D9223, D9239, D9243 | Limited to a total of 30 minutes per date of service. |

| ADA Range | Limitations/Exclusions |
| --- | --- |
| D9230 | Eligible once per date of service. |
| D9944, D9945, D9946 | Occlusal guards are removable dental appliances designed to minimize the effects of bruxism and other occlusal factors. Eligible once every 5 years. Charges to modify the appliance or for occlusal adjustment are not eligible. |
| D9973 | Eligible on anterior teeth only. Not eligible for retreatment within 3 years of the date of the previous treatment series. Not eligible for home bleaching trays and procedures. |
| D9974 | Eligible on anterior teeth only with history of root canal therapy. Not eligible for retreatment within 3 years of the date of the previous treatment series. Not eligible for home bleaching trays and procedures. |
| D9995 | Eligible one per 12 months. |

# Orthodontic Benefit Rider

**Covered Orthodontic Benefits**

Not all plans include benefits for orthodontic treatment. Orthodontic benefits, if included in the dental plan, cover certain orthodontic services and follow certain administration policies as indicated below.

The Standard Plan benefit covers the following orthodontic services:

| | |
|---|---|
| Limited Orthodontic Treatment | Interceptive Orthodontic Treatment |
| Comprehensive Orthodontic Treatment | Minor Treatment to Control Harmful Habits |

1. The dentist providing orthodontic services must file an initial claim form on behalf of the member and identify when services began, the anticipated length of the treatment period and the total cost of the treatment plan.

2. The Plan will indicate which Plan members qualify for the benefit and/or to what age the member is covered. The Standard Plan benefit covers only dependent children to a certain age, regardless of any treatment that may be in progress. Some Plans also cover adults.

3. The Plan will indicate the payment cycle for which benefits are paid. The Standard Plan benefit payment cycle makes payments of equal installments directly to the dentist on a monthly basis over a period of 24 months. The member must be an active member and be in active treatment during the entire 24 months to receive the full lifetime orthodontic benefit. If the treatment period is less than 24 months, the member's benefit will be paid only over the active treatment period and the full benefit will not be realized. If a non- standard payment cycle is selected, such as over the course of the treatment plan designated with the original claim filing, the terms will be indicated in the Plan. In the event a treatment plan is not defined with the original claim filing, the plan payment cycle will default to 24 months.

4. Active treatment is defined as treatment requiring periodic visits resulting in the movement and retention of teeth.

5. The Plan will indicate the coinsurance percentage that the member is responsible for. The Plan coinsurance may be different based on whether the dentist is a participating network or out of network dentist/orthodontist.

6. The Plan will indicate the amount of the Lifetime Orthodontic Maximum Benefit. A lifetime maximum benefit is the maximum amount paid on behalf of a member during that member's lifetime, regardless of whether a previous employer or carrier paid for the services (subject to availability of claim's information). A member is responsible for the difference between the lifetime maximum and the dentist's fee.

7. Members enrolled after the placement of braces may be eligible to receive benefits for the treatment in progress. The Plan will only consider a benefit based on the remainder of the treatment plan and will require the dentist to submit a claim for the remaining treatment plan. The member's benefit will be paid only over the remaining active treatment period and the full benefit may not be realized.

8. The Orthodontic benefit does not include benefits for lost, stolen, repairs, re-cementation, or replacement retainers. The benefit does not cover the removal of appliances for reasons other than completion of treatment.

9. Orthodontic benefits are paid "monthly" over a period of time and at the designated Plan payment amount in effect at the inception of the member's Orthodontic treatment plan. Adjustments to monthly payments will be made if the Plan Lifetime Annual benefit changes (increases or decreased) during the course of an existing treatment plan. This adjustment will only affect Plans with the Standard Benefit feature. Plans that pay benefits over a treatment plan personal to that member will "lock in" at the inception of a member's treatment plan and will not adjust over the course of the treatment as long as the Plan covers an Orthodontic Benefit. No lump sum payments will be made for any reason.

PARAMOUNT
DENTAL
*Affiliate of ProMedica*

1.3432-D.R033023.LR

© 2023 Health Resources Inc.

# Client Vision Care Plan

**Client Name:** **FOREST RIVER, INC.**
**Client Number:** **30068748**
**Effective Date:** **JANUARY 1, 2021**

## EVIDENCE OF COVERAGE

Provided by:

**VISION SERVICE PLAN INSURANCE COMPANY**
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

**Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.**

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

**This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.**

**ELIGIBILITY FOR COVERAGE**

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided.

## HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within [365] calendar days from the date services are rendered and/or materials provided. Claims received by VSP after [365] days will be denied unless prohibited by applicable state or federal law.

## TO OBTAIN FURTHER INFORMATION

**Questions regarding your policy or coverage should be directed to:**

**VSP**
**1-800-877-7195**
**or www.vsp.com.**

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits and/or Additional Benefit Rider (when purchased by Client) for details.

## COORDINATION OF BENEFITS

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

## URGENT VISION CARE

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

## HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP Preferred Provider, other than those sums not covered by the Plan.

## COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to VSP at P. O. Box 2350, Rancho Cordova, CA 95741 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

**CLAIM PAYMENTS AND DENIALS**

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: Additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], a Covered Person has the right to bring a civil action.

Time of Action: No action in law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy.

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

**THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)**

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

**DEFINITIONS:**

| | |
|---|---|
| **ADDITIONAL BENEFIT RIDER** | The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits. |
| **ASSIGNMENT OF BENEFITS** | A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider. |
| **CLIENT** | An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided. |
| **COORDINATION OF BENEFITS** | Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement. |
| **COPAYMENTS** | Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered. |
| **COVERED PERSON** | An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan. |
| **ENROLLEE** | An employee or member of Client who meets the criteria for eligibility established by Client. |
| **PLAN OR PLAN BENEFITS** | The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client). |
| **OPEN ACCESS PROVIDER** | Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP. |
| **PLAN ADMINISTRATOR** | The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client. |
| **POLICY** | The contract between VSP and Client upon which this Plan is based. |
| **SCHEDULE OF BENEFITS** | The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan. |
| **VSP PREFERRED PROVIDER** | An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP. |
| **URGENT CARE** | Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action. |

**EXHIBIT A**

**SCHEDULE OF BENEFITS**
**VSP Choice Plan®**

## GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

## BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

## ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

## PLAN BENEFITS
## VSP PREFERRED PROVIDERS

## COPAYMENT

There shall be a Copayment of $20.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

**COVERED SERVICES AND MATERIALS**

**EYE EXAMINATION- Covered in full* once every 12 months****

Comprehensive examination of visual functions and prescription of corrective eyewear.

**LENSES - Covered in full* once every 12 months****
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Standard Progressive Lenses covered in full

**LENS OPTIONS**

Scratch coating covered in full once every 12 months. **
Polycarbonate Lenses covered in full once every 12 months. **
UV (ultraviolet) protected covered in full once every 12 months. **

**FRAMES -** Covered up to the Plan allowance* once every 24 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

**CONTACT LENSES**

**ELECTIVE**

Elective Contact Lenses (materials only) are covered up to $130.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $45.00 Copayment.

**NECESSARY**
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

**LOW VISION**

Professional services for severe visual problems not correctable with regular lenses, including:

**Supplemental Testing: Covered in full*.**

**-Includes evaluation, diagnosis and prescription of vision aids where indicated.**

**Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00***

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

## NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

**REIMBURSEMENT SCHEDULE**
**OPEN ACCESS PROVIDERS**

**COPAYMENT**

There shall be a Copayment of $20.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

**COVERED SERVICES AND MATERIALS**

**EYE EXAMINATION: Up to $ 45.00* once every 12 months****
Comprehensive examination of visual functions and prescription of corrective eyewear.

**SPECTACLE LENSES**

Single Vision Up to $ 30.00* once every 12 months**

Bifocal Up to $ 50.00* once every 12 months**

Trifocal Up to $ 65.00* once every 12 months**

Lenticular Up to $100.00* once every 12 months**

**FRAMES: Covered up to $ 70.00* once every 24 months****

**CONTACT LENSES**

**ELECTIVE**
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

**NECESSARY**
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

**LOW VISION**

Professional services for severe visual problems not correctable with regular lenses, including:

**Supplemental Testing: Up to $125.00*.**

**-Includes evaluation, diagnosis and prescription of vision aids where indicated.**

**Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00***

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

**OPEN ACCESS PROVIDERS**

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

**EXHIBIT C**

**VISION SERVICE PLAN INSURANCE COMPANY**
**ADDITIONAL BENEFIT RIDER**
**DIABETIC EYECARE PLUS PROGRAM**

## GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Policy or Evidence of Coverage to which it is attached.

## ELIGIBILITY

The following are Covered Persons under this Policy, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

## PROGRAM DESCRIPTION

The Diabetic Eyecare Program (“DEP”) is intended to be a supplement to Covered Person’s group medical plan. Providers will first submit a claim to Covered Person’s group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as “Coordination of Benefits” or “COB." Please refer to the Coordination of Benefits section of Covered Person’s Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- tunnel vision
- trouble focusing
- “floating” spots
- visual distortion

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- rubeosis
- diabetic macular edema
- age-related macular degeneration
- glaucoma

## PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The DEP Plus Program provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the DEP Plus Program provides Plan Benefits as follows:

1. Covered Person contacts a VSP Preferred Doctor and makes an appointment.

2. Covered Person pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by the Plan.

## REFERRALS

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

**PLAN BENEFITS**
**VSP PREFERRED PROVIDER**

**COVERED SERVICES**

**Eye Examination:** Covered in full after a Copayment of $20.00.

**Special Ophthalmological Services:** Covered in Full.

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

**NOT COVERED**

1. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
2. Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services and/or supplies.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

## DIABETIC EYECARE PLUS PROGRAM DEFINITIONS

| | |
|---|---|
| AMD | Age-related macular degeneration (AMD) is a disease that destroys the clear, “straight ahead” central vision necessary for reading, driving, identifying faces and performing other daily tasks. |
| Diabetes | A disease where the pancreas has a problem either making, or making and using, insulin. |
| Type 1 Diabetes | A disease in which the pancreas stops making insulin. |
| Type 2 Diabetes | A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy. |
| Diabetic Retinopathy | A weakening in the small blood vessels at the back of the eye. |
| Rubeosis | Abnormal blood vessel growth on the iris and the structures in the front of the eye. |
| Diabetic Macular Edema | Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula. |
| Glaucoma | A disease in which damage to the optic nerve leads to progressive, irreversible vision loss. |
| Special Ophthalmological Services | Medical eyecare procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma and/or AMD. |

**Summary of Benefits and Coverage**
**VSP Choice Plan**

**Prepared for:** **FOREST RIVER, INC.**
**Group ID:** **30068748**
**Effective Date:** **JANUARY 1, 2021**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations and Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| If you or your dependents (if applicable) need eyecare | Eye Exam | $20.00 Copay | Reimbursed up to $45.00 | Exam covered in full every 12 months** |
| | Frames, Lenses or Contacts | Glasses: $20.00 Copay (lenses and/or frames only); Up to $45.00 copay for Contact Lens Exam | Frames reimbursed up to $ 70.00<br>SV Lenses reimbursed up to $ 30.00<br>Bi-Focal Lenses reimbursed up to $ 50.00<br>Tri-Focal Lenses reimbursed up to $ 65.00<br>Lenticular Lenses reimbursed up to $100.00<br>ECL reimbursed up to $105.00 | Frames covered every 24 months**<br>Lenses covered every 12 months** |
| | Fees | | | |

** Beginning with the first day of the Benefit Period.

**Your Grievance and Appeals Rights:**
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

AMENDMENT NO. 6

This amendment forms a part of Group Identification No. 951841 001 issued to the Employer/Applicant:

Forest River Incorporated

The entire Summary of Benefits is replaced by the Summary of Benefits attached to this amendment.

The effective date of these changes is January 1, 2026. The changes only apply to deaths and covered losses that occur and disabilities which start on or after the effective date.

The Summary of Benefits' terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on September 30, 2025.

Unum Life Insurance Company of America

By

Secretary

If this amendment is unacceptable, please sign below and return this amendment to Unum Life Insurance Company of America at Portland, Maine within 90 days of September 30, 2025.

**YOUR FAILURE TO SIGN AND RETURN THIS AMENDMENT BY THAT DATE WILL CONSTITUTE ACCEPTANCE OF THIS AMENDMENT.**

Forest River Incorporated

By _____
Signature and Title of Officer

**GROUP INSURANCE**
**SUMMARY OF BENEFITS**
**NON-PARTICIPATING**

**IDENTIFICATION NUMBER:** 951841 001

**EFFECTIVE DATE OF COVERAGE:** January 1, 2016

**ANNIVERSARY DATE:** January 1

**GOVERNING JURISDICTION:** Maine

**Unum Life Insurance Company of America**
**insures the lives of**

**Forest River Incorporated**

**under the**
**Select Group Insurance Trust**
**Policy No. 292000**

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this Summary of Benefits. Unum makes this promise subject to all of this Summary of Benefits' provisions.

The Employer should read this Summary of Benefits carefully and contact Unum promptly with any questions. This Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Signed for Unum at Portland, Maine on the Effective Date of Coverage.

President Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

## TABLE OF CONTENTS


BENEFITS AT A GLANCE ..... B@G-LIFE-1

LIFE INSURANCE PLAN ..... B@G-LIFE-1

BENEFITS AT A GLANCE ..... B@G-AD&D-1

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN ..... B@G-AD&D-1

CLAIM INFORMATION ..... LIFE-CLM-1

LIFE INSURANCE ..... LIFE-CLM-1

CLAIM INFORMATION ..... AD&D-CLM-1

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ..... AD&D-CLM-1

EMPLOYER PROVISIONS ..... EMPLOYER-1

CERTIFICATE SECTION ..... CC.FP-1

GENERAL PROVISIONS ..... EMPLOYEE-1

LIFE INSURANCE ..... LIFE-BEN-1

BENEFIT INFORMATION ..... LIFE-BEN-1

OTHER BENEFIT FEATURES ..... LIFE-OTR-1

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ..... AD&D-BEN-1

BENEFIT INFORMATION ..... AD&D-BEN-1

OTHER BENEFIT FEATURES ..... AD&D-OTR-1

STATE REQUIREMENTS ..... STATE REQ-1

OTHER SERVICES ..... SERVICES-1

GLOSSARY ..... GLOSSARY-1

# BENEFITS AT A GLANCE

## LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

**EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE:** January 1, 2016

**PLAN YEAR:**

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

**IDENTIFICATION NUMBER:** 951841 001

**ELIGIBLE GROUP(S):**

Group 1
All full-time salaried employees and hourly Administrative Clerical employees in active employment in the United States with the Employer

Group 2
All other full-time hourly employees, not eligible in another group, in active employment in the United States with the Employer

**MINIMUM HOURS REQUIREMENT:**

Employees must be regularly scheduled to work at least 20 hours per week.

**WAITING PERIOD:**

For employees in an eligible group on or before January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

For employees entering an eligible group after January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

**WHO PAYS FOR THE COVERAGE:**

**For You:**

*Basic Benefit:*

Your Employer pays the cost of your coverage.

*Additional Benefit:*

You pay the cost of your coverage.

**For Your Dependents:**

You pay the cost of your dependent coverage.

**ELIMINATION PERIOD:**

Premium Waiver: 180 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

**LIFE INSURANCE BENEFIT:**

**AMOUNT OF LIFE INSURANCE FOR YOU**

**BASIC BENEFIT**

**Group 1**
$50,000

**Group 2**
$15,000

**ADDITIONAL BENEFITS:**

Amounts in $10,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $10,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

**Group 1 - Basic and Additional Benefits**
On the January 1st coincident with or next following the date you have reached age 65, but not age 70, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 65; or
- 65% of the amount of life insurance shown above if you become insured on or after age 65 but before age 70.

There will be no further increases in your amount of life insurance.

On the January 1st coincident with or next following the date you have reached age 70 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 70.

There will be no further increases in your amount of life insurance.

**Group 2 - Additional Benefits only**
On the January 1st coincident with or next following the date you have reached age 65, but not age 70, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 65; or
- 65% of the amount of life insurance shown above if you become insured on or after age 65 but before age 70.

There will be no further increases in your amount of life insurance.

On the January 1st coincident with or next following the date you have reached age 70 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 70.

There will be no further increases in your amount of life insurance.

MAXIMUM BENEFIT OF ADDITIONAL LIFE INSURANCE FOR YOU:

The lesser of:
- 5 x annual earnings; or
- $250,000.

**AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS**

**Note:** You must be enrolled for Additional Life Benefits for yourself in order to elect coverage for your Dependents.

**Spouse:**

Amounts in $5,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $5,000, if not already an exact multiple thereof.

THE AMOUNT OF YOUR SPOUSE'S LIFE INSURANCE WILL REDUCE BY THE SAME PERCENTAGE AND AT THE SAME TIME YOUR LIFE INSURANCE REDUCES.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR SPOUSE:

$25,000

**Children:**

| | |
|---|---|
| Live birth to 6 months: | $1,000 |
| 6 months to age 19 or to 25 if a full-time student: | $10,000 |

THE AMOUNT OF LIFE INSURANCE FOR A DEPENDENT WILL NOT BE MORE THAN 50% OF YOUR AMOUNT OF ADDITIONAL LIFE INSURANCE.

**SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.**

**OTHER FEATURES:**

Accelerated Benefit

Conversion

Continuity of Coverage

Portability

Work Life Assistance Program

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

**The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. Upon request, your Employer will provide, free of charge, either an electronic or paper copy of the group insurance certificate.** The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

# BENEFITS AT A GLANCE

## ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

**EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE:** January 1, 2016

**PLAN YEAR:**

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

**IDENTIFICATION NUMBER:** 951841 001

**ELIGIBLE GROUP(S):**

Group 1
All full-time salaried employees and hourly Administrative Clerical employees in active employment in the United States with the Employer

Group 2
All other full-time hourly employees, not eligible in another group, in active employment in the United States with the Employer

**MINIMUM HOURS REQUIREMENT:**

Employees must be regularly scheduled to work at least 20 hours per week.

**WAITING PERIOD:**

For employees in an eligible group on or before January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

For employees entering an eligible group after January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

**WHO PAYS FOR THE COVERAGE:**

*Basic Benefit:*

Your Employer pays the cost of your coverage.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:**

**AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU** (FULL AMOUNT)

**BASIC BENEFIT**

An amount equal to your life amount.

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

**Group 1**
On the January 1st coincident with or next following the date you have reached age 65, but not age 70, your amount of AD&D insurance will be:
- 65% of the amount of AD&D insurance you had prior to age 65; or
- 65% of the amount of AD&D insurance shown above if you become insured on or after age 65 but before age 70.

There will be no further increases in your amount of AD&D insurance.

On the January 1st coincident with or next following the date you have reached age 70 or more, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to your first reduction; or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 70.

There will be no further increases in your amount of AD&D insurance.

**REPATRIATION BENEFIT FOR YOU**

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

**SEATBELT(S) AND AIR BAG BENEFIT FOR YOU**

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

**EDUCATION BENEFIT**

<u>Each Qualified Child</u>

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

**EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU**

Maximum Benefit Amount: The Full Amount

**SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.**

**OTHER FEATURES:**

Portability

Continuity of Coverage is available under this plan - refer to the **ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES** for further details.

**The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. Upon request, your Employer will provide, free of charge, either an electronic or paper copy of the group insurance certificate.** The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

# CLAIM INFORMATION

# LIFE INSURANCE

## *WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?*

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

## *HOW DO YOU FILE A CLAIM FOR A DISABILITY?*

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

## *WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?*

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

### *WHEN CAN UNUM REQUEST AN AUTOPSY?*

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

### *HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)*

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

In addition, if you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

### *HOW WILL UNUM MAKE PAYMENTS?*

If your or your dependent's life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

If you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse's death claim will be paid to your surviving spouse's beneficiary.

All other benefits will be paid to you.

### *WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?*

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

### *WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)*

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

# CLAIM INFORMATION

# ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

## *WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?*

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

## *HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?*

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

## *WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?*

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any **hospital or institution** where treatment was received, including all attending **physicians**.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative's expense, must show:

- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

### *WHEN CAN UNUM REQUEST AN AUTOPSY?*

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

### *HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)*

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

### *HOW WILL UNUM MAKE PAYMENTS?*

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

### *WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?*

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

### *WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)*

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

# EMPLOYER PROVISIONS

### *WHAT DOES THIS SUMMARY OF BENEFITS CONSIST OF FOR THE EMPLOYER?*

This Summary of Benefits consists of:

- all Summary of Benefits' provisions and any amendments and/or attachments issued;
- the Employer's Participation Agreement;
- each employee's application for insurance (employee retains his own copy); and
- the certificate of coverage issued for each employee of the Employer.

This Summary of Benefits may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this Summary of Benefits. No other person, including an agent, may change this Summary of Benefits or waive any part of it.

### *WHAT IS THE COST OF THIS INSURANCE?*

## LIFE INSURANCE

Premium payments are *required* for an insured while he or she is disabled under this plan.

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

#### *PREMIUM WAIVER*

Unum does not require premium payments for an insured employee's life coverage if he or she is under age 60 and disabled for 180 days. Proof of disability, provided at the insured employee's expense, must be filed by the insured employee and approved by Unum.

#### *INITIAL RATE GUARANTEE AND RATE CHANGES*

Refer to the Rate Information Amendment(s).

## ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

#### *INITIAL RATE GUARANTEE AND RATE CHANGES*

Refer to the Rate Information Amendment(s).

### *WHEN IS PREMIUM DUE FOR THIS SUMMARY OF BENEFITS?*

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Employer** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

### *WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?*

Premium increases or decreases which take effect during an insurance month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current plan year and the prior plan year. In the case of fraud, premium adjustments will be made for all plan years.

### *WHAT INFORMATION DOES UNUM REQUIRE FROM THE EMPLOYER?*

The Employer must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Employer records that, in Unum's opinion, have a bearing on this Summary of Benefits will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

### *WHO CAN CANCEL OR MODIFY THIS SUMMARY OF BENEFITS OR A PLAN UNDER THIS SUMMARY OF BENEFITS?*

This Summary of Benefits or a plan under this Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify this Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a basic benefit plan; or

- the number of employees insured for all additional benefits is less than 15 lives or 25% of those eligible, whichever is greater; or
- the number of employees insured under a plan decreases by 25%; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this Summary of Benefits; or
- fewer than 15 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of this Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 60 day **grace period**.

If Unum cancels or modifies this Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel this Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify this Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel this Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, this Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels this Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this Summary of Benefits or a plan is cancelled, the cancellation will not affect a **payable claim**.

### *WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS SUMMARY OF BENEFITS WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?*

We will continue the employee's coverage in accordance with the Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and the Employer approved the employee's leave in writing.

Coverage will be continued until the end of the latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or

- the leave period provided to the employee for injury or sickness.

If the Employer's Human Resource policy doesn't provide for continuation of a plan for an employee during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period; or
- require evidence of insurability.

***DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:***

*FOR LIFE INSURANCE:*

NAME/LOCATION (CITY AND STATE)

Maple Tree Transportation, Inc.
Elkhart, Indiana

*FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:*

NAME/LOCATION (CITY AND STATE)

Maple Tree Transportation, Inc.
Elkhart, Indiana

## CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

# GENERAL PROVISIONS

## *WHAT IS THE CERTIFICATE OF COVERAGE?*

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

## *WHEN ARE YOU ELIGIBLE FOR COVERAGE?*

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

## *WHEN DOES YOUR COVERAGE BEGIN?*

This plan provides additional life benefits in addition to the basic life benefit and the basic accidental death and dismemberment benefit. When you first become eligible for coverage, you may apply for any number of additional life benefit units, however, you cannot be covered for more than the maximum benefit available under the plan.

Your Employer pays 100% of the cost of your coverage under the basic benefit. You will automatically be covered under the basic benefit at 12:01 a.m. on the date you are eligible for coverage.

You pay 100% of the cost for the additional life benefits. You will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage, if you apply for insurance on or before that date; or
- the date you apply for insurance, if you apply within 31 days after your eligibility date.

If you do not apply for additional life benefits on or before the 31st day after your eligibility date, you can only apply at the next **annual enrollment period** or within 31 days of a **change in status.** Evidence of insurability is required for any amount of insurance.

Coverage applied for during an annual enrollment period will begin at 12:01 a.m. on the later of:

- the first day of the next plan year; or
- the date Unum approves your evidence of insurability form.

Coverage applied for due to a change in status will begin at 12:01 a.m. on the date Unum approves your evidence of insurability form.

### *WHEN CAN YOU CHANGE YOUR COVERAGE?*

You can change your coverage by applying for additional life benefit units only during an annual enrollment period or within 31 days of a change in status.

You can increase your coverage by two benefit units up to the maximum benefit available under the plan or decrease your coverage by any number of benefit units.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

A change in coverage that is made due to a change in status will begin at 12:01 a.m. on the later of:

- the date of the change in status, if you apply on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status.

Changes in coverage must be consistent with the change in status.

### *WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?*

If you are absent from work due to injury, sickness or temporary leave of absence, your coverage will begin on the date you return to **active employment**.

### *ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?*

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to 12 months.

### *ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?*

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 3 months following the date your leave of absence begins.

### *WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?*

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

### *WHEN DOES YOUR COVERAGE END?*

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

### *WHEN ARE YOU ELIGIBLE TO ELECT DEPENDENT COVERAGE?*

If you elect additional coverage for yourself, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

### *WHEN ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE?*

The date your dependents are eligible for coverage is the later of:

- the date your insurance begins; or
- the date you first acquire a dependent.

### *WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*

The following dependents are eligible for coverage under the plan:

- Your lawful spouse, including a legally separated spouse. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

- Your unmarried children from live birth but less than age 19. Stillborn children are not eligible for coverage.

- Your unmarried dependent children age 19 or over but under age 25 also are eligible if they are full-time students at an **accredited school**.

- Your unmarried **handicapped** dependent children age 25 or over who became handicapped prior to the child's attainment of age 25.

  Unum must receive proof within 31 days of the date the child is eligible for coverage under this Summary of Benefits, and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

No dependent child may be covered by more than one employee in the plan.

No dependent child can be covered as both an employee and a dependent.

### *WHEN DOES YOUR DEPENDENT COVERAGE BEGIN?*

This plan provides coverage for your dependents. When your dependents first become eligible for coverage, you may apply for:

- any number of life benefit units for your dependent spouse; however your dependent spouse cannot be covered for more than the maximum benefit available under the plan; and
- dependent child(ren) life coverage.

You pay 100% of the cost for your dependent coverage. Your dependents will be covered at 12:01 a.m. on the later of:

- the date your dependents are eligible for coverage, if you apply for insurance on or before that date; or
- the date you apply for dependent insurance, if you apply within 31 days after your dependent's eligibility date.

If you do not apply for dependent coverage on or before the 31st day after your dependent's eligibility date, you can only apply at the next annual enrollment period or within 31 days of a change in status. Evidence of insurability is required for any amount of dependent spouse life insurance. Evidence of insurability is not required for dependent child(ren).

Dependent coverage applied for during an annual enrollment period will begin at 12:01 a.m. on the later of:

- the first day of the next plan year; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

Dependent coverage applied for due to a change in status will begin at 12:01 a.m. on the latest of:

- the date of the change in status, if you apply for dependent coverage on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

### *WHEN CAN YOU CHANGE YOUR DEPENDENT COVERAGE?*

You can change your dependent spouse coverage by applying for additional life benefit units only during an annual enrollment period or within 31 days of a change in status. You can increase your dependent spouse coverage by two benefit units up to the maximum benefits available under the plan or decrease your dependent coverage any number of benefit units. In addition, you can cancel your dependent spouse and/or dependent child coverage.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

A change in coverage due to a change in status will begin at 12:01 a.m. on the later of:

- the date of the change in status, if you apply for dependent coverage on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status.

Changes in coverage must be consistent with the change in status.

### *WHAT IF YOUR DEPENDENT IS TOTALLY DISABLED ON THE DATE YOUR DEPENDENT'S COVERAGE WOULD NORMALLY BEGIN?*

If your eligible dependent is **totally disabled**, your dependent's coverage will begin on the date your eligible dependent no longer is totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.

### *WHEN WILL CHANGES TO YOUR DEPENDENT'S COVERAGE TAKE EFFECT?*

Once your dependent's coverage begins, any increased or additional dependent coverage due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required, provided your dependent is not totally disabled. You must be in active employment or on a covered leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional dependent coverage due to a plan change will begin on the date you return to active employment.

If your dependent is totally disabled, any increased or additional dependent coverage will begin on the date your dependent is no longer totally disabled.

Any decreased coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

### *WHEN DOES YOUR DEPENDENT'S COVERAGE END?*

Your dependent's coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date you no longer are covered under the additional benefits;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of divorce or annulment.

Unum will provide coverage for a payable claim which occurs while your dependents are covered under the Summary of Benefits or plan.

### *WILL COVERAGE CONTINUE FOR A HANDICAPPED CHILD INSURED UNDER THE PLAN WHO IS AGE 25 OR OVER?*

Coverage will continue for a child age 25 or over who is handicapped, provided:

- the child is currently insured under the plan; and
- the child is unmarried; and
- you are the main source of support and maintenance.

Unum must receive proof within 31 days of the date the child attains age 25 and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

### *WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?*

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

### *HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

### *HOW WILL UNUM HANDLE INSURANCE FRAUD?*

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

### *DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?*

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

### *DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?*

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

# LIFE INSURANCE

# BENEFIT INFORMATION

### *WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?*

Your beneficiary(ies) will receive payment when Unum approves your death claim.

### *WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?*

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

### *HOW MUCH WILL UNUM PAY YOU IF UNUM APPROVES YOUR DEPENDENT'S DEATH CLAIM?*

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

### *HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?*

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

### *WHAT ARE YOUR ANNUAL EARNINGS?*

"Annual Earnings" means your gross annual income from your Employer in effect prior to September 1st of the calendar year just prior to the date of loss.

Average gross annual income will be averaged using the lesser of:

a. the 12 month period of your employment with your Employer just prior to September 1 of the calendar year just prior to the date of loss; or
b. the period of actual employment with your Employer prior to September 1.

It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income received from base pay, piece rate, commissions, overtime pay and bonuses. It does not include income received from shift differential or any other extra compensation, or income received from sources other than your Employer.

The amount calculated above is frozen as of September 1 and is used to determine your annual earnings for the following calendar year.

### *WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LEAVE OF ABSENCE?*

If you become disabled while you are on a covered leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

### *WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?*

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

### *HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?*

You must be disabled through your **elimination period**.

Your elimination period is 180 days.

### *WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?*

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

### *WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?*

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

Also, we will not continue the life insurance premium waiver beyond the Maximum Benefit Period stated below based on your age on the date your disability began.

| Year of Birth | Maximum Benefit Period<br>Social Security Normal Retirement Age |
|---|---|
| 1937 or before | 65 years |
| 1938 | 65 years 2 months |
| 1939 | 65 years 4 months |
| 1940 | 65 years 6 months |
| 1941 | 65 years 8 months |
| 1942 | 65 years 10 months |
| 1943 - 1954 | 66 years |
| 1955 | 66 years 2 months |
| 1956 | 66 years 4 months |
| 1957 | 66 years 6 months |
| 1958 | 66 years 8 months |
| 1959 | 66 years 10 months |
| 1960 and after | 67 years |

### *HOW DOES UNUM DEFINE DISABILITY?*

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

### *APPLYING FOR LIFE INSURANCE PREMIUM WAIVER*

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

### *WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)*

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

### *WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*

When coverage ends under the plan, you and your dependents can convert your coverages to individual life policies, without evidence of insurability. The maximum amounts that you can convert are the amounts you and your dependents are insured for under the plan. You may convert a lower amount of life insurance.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you or your dependents no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The person may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

### *WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)*

You and your dependents may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum for each of you will be the lesser of:

- $10,000; or
- your or your dependent's coverage amounts under the plan less any amounts that become available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

### *PREMIUMS*

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

### *DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD*

If you or your dependents die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

### *APPLYING FOR CONVERSION*

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

## *WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)*

If you or your dependent becomes terminally ill while you or your dependent is insured by the plan, Unum will pay you a portion of your or your dependent's life insurance benefit one time. The payment will be based on 75% of your or your dependent's life insurance amount. However, the one-time benefit paid will not be greater than $500,000.

Your or your dependent's right to exercise this option and to receive payment is subject to the following:

- you or your dependent requests this election, in writing, on a form acceptable to Unum;
- you or your dependent must be terminally ill at the time of payment of the Accelerated Benefit;
- your or your dependent's physician must certify, in writing, that you or your dependent is terminally ill and your or your dependent's life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you or your dependent is not eligible for benefits if:

- you or your dependent is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you or your dependent is required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

Also, premium payments must continue to be paid on the full amount of your dependent's life insurance.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you or your dependent should consult your personal tax advisor to assess the impact of this benefit.

### *WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your or your dependent's initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance become effective for you or your dependent.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you or your dependent applied for at that time.

# LIFE INSURANCE

# OTHER BENEFIT FEATURES

### *WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)*

Unum will provide coverage for you and your dependent(s) if you and your dependent(s) are covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you and your dependent(s) under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you and your dependent(s) are subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

### *WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)*

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

## *PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE*

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:

- the highest amount of life insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for a child will not be more than:

- the highest amount of life insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent's amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

## *APPLYING FOR PORTABLE COVERAGE*

You must apply for portable coverage for yourself and your dependents and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

Your dependents must apply for portable coverage and pay the first premium within 31 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your dependent has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your child has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your child.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you or your dependents were not eligible for portability at the time you or your dependents elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

### *APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE*

You or your dependents may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

### *ADDING PORTABLE COVERAGE FOR DEPENDENTS*

If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

You may enroll newly acquired dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

### *WHEN PORTABLE COVERAGE ENDS*

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates);
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

### *PREMIUM RATE CHANGES FOR PORTABLE COVERAGE*

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or

- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

***APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE***

If you or your dependent is not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

# ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

# BENEFIT INFORMATION

### *WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?*

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

### *WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?*

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

### *WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?*

You will receive payment when Unum approves the claim.

### *HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?*

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

| **Covered Losses** | **Benefit Amounts** |
|---|---|
| Life | The Full Amount |
| Both Hands or Both Feet or Sight of Both Eyes | The Full Amount |
| One Hand and One Foot | The Full Amount |
| One Hand and Sight of One Eye | The Full Amount |
| One Foot and Sight of One Eye | The Full Amount |
| Speech and Hearing | The Full Amount |
| One Hand or One Foot | One Half The Full Amount |
| Sight of One Eye | One Half The Full Amount |

| | |
|---|---|
| Speech or Hearing | One Half The Full Amount |
| Thumb and Index Finger of Same Hand | One Quarter The Full Amount |

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

### *WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?*

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

### *WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?*

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a **Private Passenger Car**, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

### *WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?*

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a **qualified child**; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

### *WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?*

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

### *WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?*

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:

- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within one year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

### *WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.
- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- service on full-time active duty in the Armed Forces of any country or international authority.
- travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while:
  - it is being used for test or experimental purposes;
  - you are operating, learning to operate or serving as a member of the crew;
  - it is being operated by or for or under the direction of any military authority.

  This exclusion does not apply to:
  - transport type aircraft operated by the Military Airlift Command of the United States; or
  - similar air transport service of any other country.
- travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned or leased by or on behalf of your Employer.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being **intoxicated**.
- war, declared or undeclared, or any act of war.

# ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

# OTHER BENEFIT FEATURES

### *WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)*

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

### *WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)*

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

### *PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE*

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

### *APPLYING FOR PORTABLE COVERAGE*

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

### *APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE*

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

### *WHEN PORTABLE COVERAGE ENDS*

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

### *PREMIUM RATE CHANGES FOR PORTABLE COVERAGE*

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

# STATE REQUIREMENTS

## NOTICE

**Questions regarding your Summary of Benefits or coverage should be directed to:**

**Unum Life Insurance Company of America**
**Manager Customer Relations**
**2211 Congress Street**
**Portland, ME 04122**
**Toll free: (800) 321-3889, Option 2**
**Direct: (207) 575-7568**
**Fax: (207) 575-7963**

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

# OTHER SERVICES

This service is also available from us as part of your Unum Life Insurance Plan.

## *IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?*

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

# GLOSSARY

**ACCIDENTAL BODILY INJURY** means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

**ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT** means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

**ACCREDITED SCHOOL** means an accredited post-secondary institution of higher learning for full-time students beyond the 12th grade level.

**ACTIVE EMPLOYMENT** means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

**ANNUAL EARNINGS** means your annual income received from your Employer as defined in the plan.

**ANNUAL ENROLLMENT PERIOD** means a period of time before the beginning of each plan year.

**CHANGE IN STATUS** means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

**ELIMINATION PERIOD** means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

**EMPLOYEE** means a person who is in active employment in the United States with the Employer.

**EMPLOYER** means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

**EVIDENCE OF INSURABILITY** means a statement of your or your dependent's medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum's expense.

**GAINFUL OCCUPATION** means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

**GRACE PERIOD** means the period of time following the premium due date during which premium payment may be made.

**HANDICAPPED** means permanently and continuously incapable of self sustaining support by reason of mental or physical incapacity.

**HOSPITAL OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing your disability.

**INJURY** means:

- **for purposes of Portability**, a bodily injury that is the direct result of an accident and not related to any other cause.
- **for all other purposes**, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

**INSURED** means any person covered under a plan.

**INTOXICATED** means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

**LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a leave of absence.

**LIFE INSURANCE BENEFIT** means the total benefit amount for which an individual is insured under this plan subject to the maximum benefit.

**LIFE THREATENING CONDITION** is a critical health condition that may result in your dependent's loss of life.

**LOSS OF A FOOT** means that all of the foot is cut off at or above the ankle joint.

**LOSS OF A HAND** means that all four fingers are cut off at or above the knuckles joining each to the hand.

**LOSS OF HEARING** means the total and irrecoverable loss of hearing in both ears.

**LOSS OF SIGHT** means the eye is totally blind and that no sight can be restored in that eye.

**LOSS OF SPEECH** means the total and irrecoverable loss of speech.

**LOSS OF THUMB AND INDEX FINGER** means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

**PAYABLE CLAIM** means a claim for which Unum is liable under the terms of the Summary of Benefits.

**PHYSICIAN** means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

**PLAN** means a line of coverage under the Summary of Benefits.

**PRIVATE PASSENGER CAR** means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

**QUALIFIED CHILD** is any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:

- enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
- at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

**REGULAR CARE** means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

**RETAINED ASSET ACCOUNT** is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

**SICKNESS** means:

- **for purposes of Portability**, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.

- **for all other purposes**, an illness or disease. Disability must begin while you are covered under the plan.

**TOTALLY DISABLED** means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:

- is confined in a hospital or similar institution;
- is confined at home under the care of a physician for a sickness or injury; or
- has a **life threatening condition**.

Your dependent children:

- are confined in a hospital or similar institution; or
- are confined at home under the care of a physician for a sickness or injury.

**TRUST** means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

**WAITING PERIOD** means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

**WE**, **US** and **OUR** means Unum Life Insurance Company of America.

**YOU** means an employee who is eligible for Unum coverage.

**THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.**

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia.
Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

**If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:**

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

**For residents of Washington**

The definition for **ACTIVE EMPLOYMENT** in the **GLOSSARY** section is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL?*** (Accelerated Benefit) in the **Life Insurance Benefit Information** section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **Life Insurance Benefit Information** section is amended to remove any exclusion for death caused by suicide.

# ERISA

## Additional Summary Plan Description Information

If the Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage and the information contained in this document.

**Name of Plan:**
Forest River, Inc. Employee Benefit Plan

**Name and Address of Employer:**
Forest River Incorporated
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46514

**Plan Identification Number:**
a. Employer IRS Identification #: 20-3284366
b. Plan #: 510

**Type of Welfare Plan:**
Life and Accidental Death and Dismemberment

**Type of Administration:**
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benefits issued to the Plan.

**ERISA Plan Year Ends:**
December 31

**Plan Administrator, Name, Address, and Telephone Number:**
Forest River Incorporated
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46514
(574) 389-4600

Forest River Incorporated is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

**Agent for Service of Legal Process on the Plan:**
Forest River Incorporated
55470 County Road 1

PO Box 3030
Elkhart, Indiana
46514

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 951841 001. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

## EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

## EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE

The Employer can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

## MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a basic benefit plan; or
- the number of employees insured for all additional benefits is less than 15 lives or 25% of those eligible, whichever is greater; or
- the number of employees insured under a plan decreases by 25%; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to the Summary of Benefits; or
- fewer than 15 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or

- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 60 day grace period.

If Unum cancels or modifies the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

## HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

## CLAIMS PROCEDURES

### If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**If a claim is based on your disability**

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

## APPEAL PROCEDURES

### If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

### If an appeal is based on your disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that

information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or 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".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

## YOUR RIGHTS UNDER ERISA

As a participant in the 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 the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps 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 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 Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's 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, if, for example, it finds your claim is frivolous.

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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

**Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or summary of benefits and effective for claims filed on or after April 1, 2018.**

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or summary of benefits conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

# Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

**COLLECTING INFORMATION**
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

**SHARING INFORMATION**
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

**SAFEGUARDING INFORMATION**
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

**ACCESS TO INFORMATION**
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you

through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

**CORRECTION OF INFORMATION**
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

**COVERAGE DECISIONS**
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

**CONTACTING US**
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

2020 Unum Group. All rights reserved. Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

unum.com MK-1883 (06-2020)

# NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

## Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

### Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

### Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

### Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

**The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**

# Forest River, Inc.

## Your Group Short Term Disability Plan

Policy No. 951839 011

Underwritten by Unum Life Insurance Company of America

4/7/2017

# CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

## TABLE OF CONTENTS


BENEFITS AT A GLANCE ..... B@G-STD-1

SHORT TERM DISABILITY PLAN ..... B@G-STD-1

CLAIM INFORMATION ..... STD-CLM-1

SHORT TERM DISABILITY ..... STD-CLM-1

GENERAL PROVISIONS ..... EMPLOYEE-1

SHORT TERM DISABILITY ..... STD-BEN-1

BENEFIT INFORMATION ..... STD-BEN-1

OTHER BENEFIT FEATURES ..... STD-OTR-1

STATE REQUIREMENTS ..... STATE REQ-1

GLOSSARY ..... GLOSSARY-1

# BENEFITS AT A GLANCE

## SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. In some cases, you can receive disability payments even if you work while you are disabled.

**EMPLOYER'S ORIGINAL PLAN**
**EFFECTIVE DATE:** January 1, 2016

**POLICY NUMBER:** 951839 011

**ELIGIBLE GROUP(S):**

All full-time employees in active employment in the United States with the Employer

**MINIMUM HOURS REQUIREMENT:**

Employees must be regularly scheduled to work at least 20 hours per week.

**WAITING PERIOD:**

For employees in an eligible group on or before the plan effective date: First of the month coincident with or next following 2 months of continuous active employment

For employees entering an eligible group after the plan effective date: First of the month coincident with or next following 2 months of continuous active employment

Employees are not eligible for coverage until the waiting period has been completed.

**ENROLLMENT:**

Employees who are eligible may apply for their coverage at any time within the first 31 days of being eligible.

After 31 days, employees who are eligible may apply for their coverage during any scheduled enrollment period.

You may cancel any coverage for which you make contributions at any time.

**EVIDENCE OF INSURABILITY:**

Evidence of insurability is required:

- for any amount of coverage applied for more than 31 days after you are first eligible for coverage.
- if you reapply for coverage after it terminates.

**CREDIT PRIOR SERVICE:**

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

**WHO PAYS FOR THE COVERAGE:**

You must make contributions for your coverage.

Premium contributions are required for your coverage while you are receiving benefit payments under this plan.

**ELIMINATION PERIOD:**

14 days for disability due to an injury

14 days for disability due to a sickness

Benefits begin the day after the elimination period is completed.

**WEEKLY BENEFIT:**

60% of weekly earnings to a maximum benefit of $600 per week

**Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.**

Your Short Term Disability plan does not cover disabilities due to an occupational sickness or injury.

**MINIMUM WEEKLY BENEFIT:**

$20

**MAXIMUM PERIOD OF PAYMENT:**

11 weeks

**OTHER FEATURES:**

Continuity of Coverage

Pre-Existing: 3/6

Rehabilitation and Return to Work Assistance Benefit

Survivor Benefit

**The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage and if you make contributions to the plan, refer to your confirmation of coverage. The plan includes enrollment, risk management and other support services related to your Employer's benefit program. Upon request, your Employer will provide, free of charge, either an electronic or paper copy of the group insurance certificate.**

# CLAIM INFORMATION

# SHORT TERM DISABILITY

## *WHEN DO YOU NOTIFY UNUM OF A CLAIM?*

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in this policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

## *HOW DO YOU FILE PROOF OF CLAIM?*

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

## *WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?*

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your weekly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

### *TO WHOM WILL UNUM MAKE PAYMENTS?*

Unum will make payments to you.

### *WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?*

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum weekly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us by offsetting against amounts otherwise payable to you under this policy, or by other legally permitted means.

# GENERAL PROVISIONS

### *WHAT IS THE CERTIFICATE OF COVERAGE?*

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

### *WHEN ARE YOU ELIGIBLE FOR COVERAGE?*

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

### *WHEN DOES YOUR COVERAGE BEGIN?*

Your coverage will begin at 12:01 a.m. on the first of the month coincident with or next following the latest of:

- the date you are eligible for coverage;
- the date you apply for coverage; or
- the date Unum approves your application, if **evidence of insurability** is required.

### *WHEN CAN YOU APPLY FOR COVERAGE IF YOU DID NOT APPLY OR DECLINED WHEN YOU WERE FIRST ELIGIBLE FOR COVERAGE OR YOU VOLUNTARILY CANCELLED YOUR COVERAGE?*

You can apply for coverage only during a **scheduled enrollment period**. Evidence of insurability is required. Unum and your Employer determine when the scheduled enrollment period begins and ends. Your coverage will begin at 12:01 a.m. on the first of the month coincident with or next following the date Unum approves your application.

An evidence of insurability form can be obtained from your Employer.

### *WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?*

If you are absent from work due to injury, sickness or leave of absence, your coverage will begin on the first of the month coincident with or next following the date you return to **active employment**.

### *ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?*

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 3 months following the date your leave of absence begins.

### *WHAT HAPPENS TO YOUR COVERAGE UNDER THIS POLICY WHILE YOU ARE ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?*

We will continue your coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer has approved your leave in writing.

Your coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical leave of absence, your coverage will be reinstated when you return to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing condition exclusion; or
- require evidence of insurability.

### *WHEN WILL CHANGES MADE BY YOUR EMPLOYER TAKE EFFECT?*

Once your coverage begins, any change requested by your Employer will take effect on the first of the month coincident with or next following the date the change occurs if you are in active employment.

If you are not in active employment due to injury or sickness, or if you are on a covered leave of absence, any change requested by your Employer will begin on the first of the month coincident with or next following the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the effective date of the change.

### *WHEN DOES YOUR COVERAGE END?*

If you choose to cancel your coverage under the policy or a plan, your coverage ends on the first of the month following the date you provide notification to your Employer.

Otherwise, your coverage under the policy or a plan ends on the earliest of the following:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment.

However, as long as premium is paid as required, coverage will continue:

- while benefits are being paid;
- while you are fulfilling the requirements of your elimination period; or
- in accordance with the leave of absence provision of this policy or plan.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

### *WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?*

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

### *HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*

Unum considers any statements you make in a signed application for coverage or evidence of insurability form, or that your Employer makes in the application process, a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

As a basis for doing this, we will use only statements made by the Employer in the application process or statements made by you in a signed application or evidence of insurability form. These statements cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

However, if the Employer gives us information about you that is incorrect, we will:

- use the facts to determine if you have coverage under the plan according to the policy provisions and in what amounts; and
- make a fair adjustment of the premium.

### *HOW MAY UNUM COMMUNICATE WITH YOU OR YOUR EMPLOYER?*

Unum may provide notices, information and other communications to you or your Employer in written, electronic or telephonic form.

### *HOW WILL UNUM HANDLE INSURANCE FRAUD?*

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

### *DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?*

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

### *DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?*

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

# SHORT TERM DISABILITY

# BENEFIT INFORMATION

### *HOW DOES UNUM DEFINE DISABILITY?*

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

### *HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?*

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 14 days.

If your disability is the result of a sickness, your elimination period is 14 days.

### *CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?*

Yes, provided you meet the definition of disability.

### *WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?*

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment weekly for any period for which Unum is liable.

### *HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?*

We will follow this process to figure your payment:

1. Multiply your weekly earnings by 60%.
2. The maximum **weekly benefit** is $600.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

### *WHAT ARE YOUR WEEKLY EARNINGS?*

"Weekly Earnings" means your average gross weekly income from your Employer for the lesser of the previous 12 full calendar month period just prior to your date of disability or the period of your employment with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from piece rate, commissions, overtime pay, and bonuses but does not include income received from shift differential or any other extra compensation, or income received from sources other than your Employer.

### *WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LEAVE OF ABSENCE?*

If you become disabled while you are on a covered leave of absence, we will use your weekly earnings from your Employer in effect just prior to the date your absence begins.

### *HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?*

We will send you the weekly payment if you are disabled and your weekly **disability earnings**, if any, are less than 20% of your weekly earnings.

If you are disabled and your weekly disability earnings are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount Unum will pay you for each week.

Unum may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

### *HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?*

If your disability earnings have fluctuated from week to week, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 weeks.

### *WHAT ARE DEDUCTIBLE SOURCES OF INCOME?*

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.
   - **governmental retirement system**.

2. The amount that you receive:

   - under the mandatory portion of any "no fault" motor vehicle **plan**.
   - under a **salary continuation** or **accumulated sick leave** plan.
   - under Title 46, United States Code Section 688 (The Jones Act).
   - from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

3. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

4. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your **Employer's contribution** to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed

simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable for the same period of disability for which we are paying benefits.

### *WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?*

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans

### *WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)*

The minimum weekly payment is: $20.

Unum may apply this amount toward an outstanding overpayment.

However, the minimum weekly payment will not be paid if you are receiving salary continuation or accumulated sick leave payments from your Employer.

### *WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?*

When we determine that you may qualify for benefits under Item(s) 1 in the deductible sources of income section, we will estimate your entitlement to these benefits and your Short Term Disability payment will be reduced by these estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1 in the deductible sources of income section, and if denied, appeal to all administrative levels Unum feels are necessary;
- provide documentation of your application and/or appeal; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

### *HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?*

Unum will send you a payment each week up to the **maximum period of payment.** Your maximum period of payment is 11 weeks during a continuous period of disability.

### *WHEN WILL PAYMENTS STOP?*

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** and you do not;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

### *WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury**, however, Unum will cover disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

***WHAT IS A PRE-EXISTING CONDITION?***

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 6 months after your effective date of coverage.

***WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?***

1. If your current disability is related to or due to the same cause(s) as your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for 14 consecutive days or less.

   If you return to work on the 15th day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.

2. If your current disability is unrelated to your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for less than 1 full day.

Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the policy provisions.

If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the Unum plan.

# SHORT TERM DISABILITY

# OTHER BENEFIT FEATURES

### *WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)*

When Unum receives proof that you have died, we will pay your eligible survivor a lump sum benefit equal to the lesser of:

1. $5,000;
2. 3 weeks of your gross disability payment; or
3. the maximum Survivor Benefit allowed by state law.

The Survivor Benefit will be paid if, on the date of your death:

- you were disabled; and
- you were receiving or were entitled to receive payments under the plan for at least 15 consecutive days during this period of disability.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 weeks of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving weekly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 week survivor benefit will be payable upon your death.

### *WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)*

Unum will provide coverage for you if, as of the effective date of this policy you were covered by the prior policy on the day before the effective date of this policy.

Your coverage is subject to payment of premium and all other terms of this policy. If you are on a leave of absence on the effective date of this policy we will consider your leave of absence to have started on that date and your coverage will continue for the period provided in this policy.

If you have not returned to active employment before your disability begins, your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by an amount for which your prior carrier is liable.

***WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM OR AFTER YOU BECOME INSURED UNDER THE UNUM PLAN DUE TO A MERGER, ACQUISITION OR AFFILIATION? (Continuity of Coverage)***

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the weekly benefit that would have been payable under the terms of the prior plan if it had remained in force; or
b. the weekly payment under the Unum plan.

Your elimination period will be the longer of:

a. the elimination period under the prior plan if it had remained in force; or
b. the elimination period under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

### *HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?*

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

### *WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?*

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $250 per week.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

### *WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?*

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which weekly payments would stop in accordance with this plan.

# STATE REQUIREMENTS

## NOTICE

**Questions regarding your policy or coverage should be directed to:**

**Unum Life Insurance Company of America**
**Manager Customer Relations**
**2211 Congress Street**
**Portland, ME 04122**
**Toll free: (800) 321-3889, Option 2**
**Direct: (207) 575-7568**
**Fax: (207) 575-7963**

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

# GLOSSARY

**ACTIVE EMPLOYMENT** means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be regularly scheduled to work on average at least the minimum number of hours as described under the minimum hours requirement in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

**DEDUCTIBLE SOURCES OF INCOME** means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

**DISABILITY EARNINGS** means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

**ELIMINATION PERIOD** means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

**EMPLOYEE** means a person who is in active employment in the United States with the Employer.

**EMPLOYER** means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

**EMPLOYER'S CONTRIBUTION** in the context of a retirement plan that is part of any federal, state, county, municipal or association retirement system means any contribution made by your Employer and any contribution made on your behalf which has been picked up by your Employer under Internal Revenue Code Section 414(h)(2) so that it does not constitute taxable income to you.

**EVIDENCE OF INSURABILITY** means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

**GOVERNMENTAL RETIREMENT SYSTEM** means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

**GRACE PERIOD** means the period of time following the premium due date during which premium payment may be made.

**GROSS DISABILITY PAYMENT** means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

**HOSPITAL OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing your disability.

**INJURY** means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

**INSURED** means any person covered under a plan.

**LAW, PLAN OR ACT** means the original enactments of the law, plan or act and all amendments.

**LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a leave of absence.

**LIMITED** means what you cannot or are unable to do.

**MATERIAL AND SUBSTANTIAL DUTIES** means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

**MAXIMUM CAPACITY** means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time Unum will make payments to you for any one period of disability.

**OCCUPATIONAL SICKNESS OR INJURY** means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

**PART-TIME BASIS** means the ability to work and earn between 20% and 80% of your weekly earnings.

**PAYABLE CLAIM** means a claim for which Unum is liable under the terms of the policy.

**PHYSICIAN** means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a physician for a claim that you send to us.

**PLAN** means a line of coverage under the policy.

**PRE-EXISTING CONDITION** means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

**REGULAR CARE** means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

**REGULAR OCCUPATION** means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

**RETIREMENT PLAN** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

**SALARY CONTINUATION OR ACCUMULATED SICK LEAVE** means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

**SCHEDULED ENROLLMENT PERIOD** means a period of time determined by Unum and your Employer.

**SICKNESS** means an illness or disease. Disability must begin while you are covered under the plan.

**SURVIVOR, ELIGIBLE** means your spouse, if living; otherwise your children under age 25 equally.

**WAITING PERIOD** means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

**WE**, **US** and **OUR** means Unum Life Insurance Company of America.

**WEEKLY BENEFIT** means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

**WEEKLY EARNINGS** means your gross weekly income from your Employer as defined in the plan.

**WEEKLY PAYMENT** means your payment after any deductible sources of income have been subtracted from your gross disability payment.

**YOU** means an employee who is eligible for Unum coverage.

# ERISA

## Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

**Name of Plan:**
Group Short Term Disability Insurance for Employees of Forest River, Inc.

**Name and Address of Employer:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46515-3030

**Plan Identification Number:**
a. Employer IRS Identification #: 20-3284366
b. Plan #: 510

**Type of Welfare Plan:**
Disability

**Type of Administration:**
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

**ERISA Plan Year Ends:**
December 31

**Plan Administrator, Name, Address, and Telephone Number:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46515-3030
(574) 389-4600

Forest River, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

**Agent for Service of Legal Process on the Plan:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46515-3030

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 951839 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

## EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

## EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

The Employer can request a policy change. Only an officer of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

## MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- our participation requirements are not met, as applicable;
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Employer and/or its employees; or
- a change in federal or state law or regulation substantially impacts the policy or the risks insured.

If Unum cancels or modifies the policy or a plan, for any of the reasons listed above, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

If any premium is not paid during the 60 day grace period, the policy or plan will terminate automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum for premium due for the full period the policy is in force. In the event of termination, the policy or plan may be reinstated only as agreed upon by Unum and the Employer. If Unum agrees to reinstate the policy or plan, such reinstatement will not constitute waiver of the termination provision in the future.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

## HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

## CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or 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".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

## YOUR RIGHTS UNDER ERISA

As a participant in the 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 the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps 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 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 Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's 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, if, for example, it finds your claim is frivolous.

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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

## OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

## NOTICE OF PROTECTION PROVIDED BY THE

INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

**Basic Protections Currently Provided by ILHIGA**

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after January 1, 2013.

**Life Insurance**

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

**Health Insurance**

- $500,000 in basic hospital, medical and surgical or major medical insurance benefits
- $300,000 in disability and long term care insurance
- $100,000 in other types of health insurance

**Annuities**

- $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- $5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
317-232-2385

**The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**

# Forest River, Inc.

## Your Group Long Term Disability Plan

Policy No. 951840 011

Underwritten by Unum Life Insurance Company of America

10/22/2020

# CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

## TABLE OF CONTENTS


BENEFITS AT A GLANCE .....B@G-LTD-1

LONG TERM DISABILITY PLAN .....B@G-LTD-1

CLAIM INFORMATION .....LTD-CLM-1

LONG TERM DISABILITY.....LTD-CLM-1

GENERAL PROVISIONS.....EMPLOYEE-1

LONG TERM DISABILITY.....LTD-BEN-1

BENEFIT INFORMATION .....LTD-BEN-1

OTHER BENEFIT FEATURES.....LTD-OTR-1

STATE REQUIREMENTS.....STATE REQ-1

OTHER SERVICES.....SERVICES-1

GLOSSARY.....GLOSSARY-1

# BENEFITS AT A GLANCE

## LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

**EMPLOYER'S ORIGINAL PLAN**
**EFFECTIVE DATE:** January 1, 2016

**POLICY NUMBER:** 951840 011

**ELIGIBLE GROUP(S):**

Group 1
Executives and General Managers with 3 or More Years of Service in active employment in the United States with the Employer

Group 2
All other full-time salaried employees, not eligible in another group, with 3 or More Years of Service in active employment in the United States with the Employer

Group 3
Executives and General Managers with at least 1 but less than 3 Years of Service in active employment in the United States with the Employer

Group 4
All other full-time salaried employees, not eligible in another group, with at least 1 but less than 3 Years of Service in active employment in the United States with the Employer

Group 5
Grandfathered hourly employees (Closed Class) in active employment in the United States with the Employer

**MINIMUM HOURS REQUIREMENT:**

Employees must be regularly scheduled to work at least 20 hours per week.

**WAITING PERIOD:**

For employees in an eligible group on or before January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

For employees entering an eligible group after January 1, 2016: First of the month following 12 months of continuous active employment

**CREDIT PRIOR SERVICE:**

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

**WHO PAYS FOR THE COVERAGE:**

Your Employer pays the cost of your coverage.

Your Employer includes the cost of your Employer-paid coverage in your taxable income.

**ELIMINATION PERIOD:**

90 days

Accumulation Period: 180 days

Benefits begin the day after the elimination period is completed.

**MONTHLY BENEFIT:**

**Groups 1 and 3**
60% of monthly earnings to a maximum benefit of $15,000 per month.

**Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.**

**Groups 2, 4 and 5**
60% of monthly earnings to a maximum benefit of $10,000 per month.

**Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.**

**MAXIMUM PERIOD OF PAYMENT:**

**Groups 1, 2 and 5**

| Age at Disability | Maximum Period of Payment |
|---|---|
| Less than Age 62 | To Social Security Normal Retirement Age |
| Age 62 | 60 months |
| Age 63 | 48 months |
| Age 64 | 42 months |
| Age 65 | 36 months |
| Age 66 | 30 months |
| Age 67 | 24 months |
| Age 68 | 18 months |
| Age 69 or older | 12 months |

| Year of Birth | Social Security Normal Retirement Age |
|---|---|
| 1937 or before | 65 years |
| 1938 | 65 years 2 months |
| 1939 | 65 years 4 months |
| 1940 | 65 years 6 months |
| 1941 | 65 years 8 months |
| 1942 | 65 years 10 months |
| 1943-1954 | 66 years |
| 1955 | 66 years 2 months |
| 1956 | 66 years 4 months |
| 1957 | 66 years 6 months |
| 1958 | 66 years 8 months |
| 1959 | 66 years 10 months |
| 1960 and after | 67 years |

**Groups 3 and 4**

| Age at Disability | Maximum Period of Payment |
|---|---|
| Less than age 68 | 2 years |
| Age 68 | To age 70, but not less than 1 year |
| Age 69 and over | 1 year |

No premium payments are required for your coverage while you are receiving payments under this plan.

**REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:**

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

**DEPENDENT CARE EXPENSE BENEFIT:**

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

**TOTAL BENEFIT CAP:**

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

**OTHER FEATURES:**

Continuity of Coverage

Conversion

Disability Plus

Minimum Benefit

Pre-Existing: 3/12

Survivor Benefit

**The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. Upon request, your Employer will provide, free of charge, either an electronic or paper copy of the group insurance certificate.**

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

# CLAIM INFORMATION

# LONG TERM DISABILITY

## *WHEN DO YOU NOTIFY UNUM OF A CLAIM?*

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in the policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

## *HOW DO YOU FILE PROOF OF CLAIM?*

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

## *WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?*

**Group 1**
Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

**Groups 2, 3, 4 and 5**
Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation or of any other gainful occupation for which you are reasonably fitted by education, training, or experience;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

## *TO WHOM WILL UNUM MAKE PAYMENTS?*

Unum will make payments to you.

## *WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?*

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum monthly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us by offsetting against amounts otherwise payable to you under this policy, or by other legally permitted means.

# GENERAL PROVISIONS

### *WHAT IS THE CERTIFICATE OF COVERAGE?*

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

### *WHEN ARE YOU ELIGIBLE FOR COVERAGE?*

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

### *WHEN DOES YOUR COVERAGE BEGIN?*

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

### *WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?*

If you are absent from work due to injury, sickness or temporary leave of absence, your coverage will begin on the date you return to **active employment**.

### *ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?*

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 3 months following the date your leave of absence begins.

### *WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?*

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

### *WHEN DOES YOUR COVERAGE END?*

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;

- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

### *WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?*

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

### *HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this. These statements cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

However, if the Employer gives us information about you that is incorrect, we will:

- use the facts to determine if you have coverage under the plan according to the policy provisions and in what amounts; and
- make a fair adjustment of the premium.

### *HOW WILL UNUM HANDLE INSURANCE FRAUD?*

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

### *DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?*

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

### *DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?*

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

# LONG TERM DISABILITY

# BENEFIT INFORMATION

## *HOW DOES UNUM DEFINE DISABILITY?*

**Group 1**
You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

**Groups 2 and 5**
You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 36 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

**Groups 3 and 4**
You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

### *HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?*

You must be continuously disabled through your **elimination period**. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 90 days.

In addition, if you return to work while satisfying your elimination period, and are no longer disabled, you may satisfy your elimination period within the **accumulation period**. You do not need to be continuously disabled through your elimination period if you are satisfying your elimination period under this provision. If you do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

Your accumulation period is 180 days.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

### *CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?*

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

### *WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?*

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

### *HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?*

We will follow this process to figure your payment:

**Groups 1 and 3**

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $15,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

**Groups 2, 4 and 5**

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $10,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

### *WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?*

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

### *WHAT ARE YOUR MONTHLY EARNINGS?*

"Monthly Earnings" means your average gross monthly income from your Employer for the lesser of the previous 12 full calendar month period just prior to your date of disability or the period of your employment with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from piece rate, commissions, overtime pay, and bonuses but does not include income received from shift differential or any other extra compensation, or income received from sources other than your Employer.

### *WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LEAVE OF ABSENCE?*

If you become disabled while you are on a covered leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

### *HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?*

We will send you the monthly payment if you are disabled and your monthly **disability earnings**, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 24 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 24 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount Unum will pay you each month.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

### *HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?*

If your disability earnings have fluctuated from month to month, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 months.

### *WHAT ARE DEDUCTIBLE SOURCES OF INCOME?*

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:

   - a workers' compensation law.
   - an occupational disease law.
   - any other **act** or **law** with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.

- **governmental retirement system**.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

   - the United States Social Security Act.
   - the Canada Pension **Plan**.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:

   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

8. The amount that you receive under the mandatory portion of any "no fault" motor vehicle **plan**.

9. The amount that you receive under a **salary continuation** or **accumulated sick leave** plan.

10. The amount that you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

***WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?***

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans

***WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)***

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

### *WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?*

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

### *WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?*

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

### *HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?*

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

**Groups 1, 2 and 5**

| Age at Disability | Maximum Period of Payment |
|---|---|
| Less than Age 62 | To Social Security Normal Retirement Age |
| Age 62 | 60 months |
| Age 63 | 48 months |
| Age 64 | 42 months |
| Age 65 | 36 months |
| Age 66 | 30 months |
| Age 67 | 24 months |

| | |
|---|---|
| Age 68 | 18 months |
| Age 69 or older | 12 months |

| Year of Birth | Social Security Normal Retirement Age |
|---|---|
| 1937 or before | 65 years |
| 1938 | 65 years 2 months |
| 1939 | 65 years 4 months |
| 1940 | 65 years 6 months |
| 1941 | 65 years 8 months |
| 1942 | 65 years 10 months |
| 1943-1954 | 66 years |
| 1955 | 66 years 2 months |
| 1956 | 66 years 4 months |
| 1957 | 66 years 6 months |
| 1958 | 66 years 8 months |
| 1959 | 66 years 10 months |
| 1960 and after | 67 years |

**Groups 3 and 4**

| Age at Disability | Maximum Period of Payment |
|---|---|
| Less than age 68 | 2 years |
| Age 68 | To age 70, but not less than 1 year |
| Age 69 and over | 1 year |

***WHEN WILL PAYMENTS STOP?***

We will stop sending you payments and your claim will end on the earliest of the following:

**Group 1**
- when you are able to work in your regular occupation on a **part-time basis** and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

**Groups 2 and 5**
- during the first 36 months of payments, when you are able to work in your regular occupation on a **part-time basis** and you do not;
- after 36 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;

- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

**Groups 3 and 4**
- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** and you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

### *WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?*

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** and disabilities based primarily on **self-reported symptoms** is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

- are not continuous; and/or
- are not related.

However, Unum will send you payments beyond the 24 month period if you meet one of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. If you are not confined to a hospital or institution but become confined for a period of at least 14 days within 90 days after the 24 month period for which you

have received payments, Unum will send payments during the length of the confinement.

Under no circumstances will Unum pay beyond the maximum period of payment as indicated in the **BENEFITS AT A GLANCE** section of your policy.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

### *WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- attempt to commit or commission of a crime.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

### *WHAT IS A PRE-EXISTING CONDITION?*

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

### *WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?*

If you have a **recurrent disability**, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.

# LONG TERM DISABILITY

# OTHER BENEFIT FEATURES

### *WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)*

When Unum receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

### *WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)*

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.

### *WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)*

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

### *WHAT INSURANCE IS AVAILABLE IF YOU END EMPLOYMENT? (Conversion)*

If you end employment with your Employer, your coverage under the plan will end. You may be eligible to purchase insurance under Unum's group conversion policy. To be eligible, you must have been insured under your Employer's group plan for at least 12 consecutive months. We will consider the amount of time you were insured under the Unum plan and the plan it replaced, if any.

You must apply for insurance under the conversion policy and pay the first quarterly premium within 31 days after the date your employment ends.

Unum will determine the coverage you will have under the conversion policy. The conversion policy may not be the same coverage we offered you under your Employer's group plan.

You are not eligible to apply for coverage under Unum's group conversion policy if:

- you are or become insured under another group long term disability plan within 31 days after your employment ends;
- you are disabled under the terms of the plan;
- you recover from a disability and do not return to work for your Employer;
- you are on a leave of absence; or
- your coverage under the plan ends for any of the following reasons:
  - the plan is cancelled;
  - the plan is changed to exclude the group of employees to which you belong;
  - you are no longer in an eligible group;
  - you end your working career or retire and receive payment from any Employer's retirement plan; or
  - you fail to pay the required premium under this plan.

### *HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?*

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

### *WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?*

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

### *WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?*

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

### *WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?*

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per **dependent**; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.

## DISABILITY PLUS RIDER

### *WHO IS ELIGIBLE FOR DISABILITY PLUS COVERAGE?*

You must be insured under the Unum Long Term Disability (LTD) plan to be eligible for the additional disability coverage described in this Rider. All of the policy definitions apply to the coverage as well as policy provisions specified in this Rider.

### *WHEN WILL THIS COVERAGE BECOME EFFECTIVE?*

You will become insured for Disability Plus coverage on the later of:

- the effective date of this Rider; or
- your effective date under the LTD plan.

Disability Plus coverage will continue as long as the Rider is in effect and you are insured under the LTD plan. There is no conversion privilege feature for Disability Plus coverage.

### *WHEN WILL YOU BE ELIGIBLE TO RECEIVE DISABILITY PLUS BENEFITS?*

We will pay a monthly Disability Plus benefit to you when we receive proof that you are disabled under this rider and are receiving monthly payments under the LTD plan. Disability Plus benefits will begin at the end of the elimination period shown in the LTD plan.

You are disabled under this rider when Unum determines that due to sickness or injury:

- you lose the ability to safely and completely perform 2 **activities of daily living** without another person's assistance or verbal cueing; or
- you have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for your protection or for the protection of others.

### *HOW MUCH WILL UNUM PAY IF YOU ARE DISABLED?*

The Disability Plus benefit is 10% of monthly earnings to a maximum monthly benefit of the lesser of the LTD plan maximum monthly benefit or $5,000.

This benefit is not subject to policy provisions, except for the Total Benefit Cap, which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

### *WHAT EXCLUSIONS AND LIMITATIONS APPLY TO DISABILITY PLUS?*

All of the policy provisions that exclude or limit coverage will apply to this Disability Plus Rider.

For Disability Plus coverage, you will be considered to have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date under this rider; and

- the disability begins in the first 12 months after your effective date under this rider.

You will not receive this benefit for a loss resulting from one of the following conditions, if the loss exists on the effective date of your coverage under this rider:

- a loss of the ability to safely and completely perform any activities of daily living without another person's assistance or verbal cueing; and/or
- a deterioration or loss in intellectual capacity and need for another person's assistance or verbal cueing for your protection or for the protection of others.

***WHAT CLAIMS INFORMATION IS NEEDED FOR DISABILITY PLUS?***

The LTD claim information section under the policy applies to Disability Plus coverage. We may ask you to be examined, at our expense, by a physician and/or other medical practitioner of our choice. We may also require an interview with you.

***WHEN WILL DISABILITY PLUS BENEFIT PAYMENTS END?***

Benefit payments will end on the earliest of the following dates:

- the date you are no longer disabled under the Rider;
- the date you become ineligible for monthly payments under the LTD plan;
- the end of the maximum period of payment shown in the LTD plan; or
- the date you die.

No survivor benefits are payable for the Disability Plus coverage.

***WHAT IS THE WAIVER OF PREMIUM FOR DISABILITY PLUS?***

Premium for the Disability Plus coverage is not required while you are receiving monthly payments under the LTD plan.

# STATE REQUIREMENTS

## NOTICE

**Questions regarding your policy or coverage should be directed to:**

**Unum Life Insurance Company of America**
**Manager Customer Relations**
**2211 Congress Street**
**Portland, ME 04122**
**Toll free: (800) 321-3889, Option 2**
**Direct: (207) 575-7568**
**Fax: (207) 575-7963**

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

# OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

### *HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?*

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

### *HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?*

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

# GLOSSARY

**ACCUMULATION PERIOD** means the period of time from the date disability begins during which you must satisfy the elimination period.

**ACTIVE EMPLOYMENT** means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

**ACTIVITIES OF DAILY LIVING** mean:

- Bathing - the ability to wash yourself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing - the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- Toileting - the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
- Transferring - the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - the ability to either:
  - voluntarily control bowel and bladder function; or
  - if incontinent, be able to maintain a reasonable level of personal hygiene.
- Eating - the ability to get nourishment into the body.

**DEDUCTIBLE SOURCES OF INCOME** means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

**DEPENDENT** means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

**DISABILITY EARNINGS** means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

**ELIMINATION PERIOD** means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

**EMPLOYEE** means a person who is in active employment in the United States with the Employer.

**EMPLOYER** means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

**Groups 2, 3, 4 and 5**
**GAINFUL OCCUPATION** means an occupation that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

80% of your indexed monthly earnings, if you are working; or
60% of your indexed monthly earnings, if you are not working.

**GOVERNMENTAL RETIREMENT SYSTEM** means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

**GRACE PERIOD** means the period of time following the premium due date during which premium payment may be made.

**GROSS DISABILITY PAYMENT** means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

**HOSPITAL OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing your disability.

**Group 1**
**INDEXED MONTHLY EARNINGS** means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working.

**Groups 2, 3, 4 and 5**
**INDEXED MONTHLY EARNINGS** means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

**INJURY** means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

**INSURED** means any person covered under a plan.

**LAW, PLAN OR ACT** means the original enactments of the law, plan or act and all amendments.

**LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a leave of absence.

**LIMITED** means what you cannot or are unable to do.

**MATERIAL AND SUBSTANTIAL DUTIES** means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

**Group 1**
**MAXIMUM CAPACITY** means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

**Groups 2 and 5**
**MAXIMUM CAPACITY** means, based on your restrictions and limitations:

- during the first 36 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 36 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

**Groups 3 and 4**
**MAXIMUM CAPACITY** means, based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time Unum will make payments to you for any one period of disability.

**MENTAL ILLNESS** means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

**MONTHLY BENEFIT** means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

**MONTHLY EARNINGS** means your gross monthly income from your Employer as defined in the plan.

**MONTHLY PAYMENT** means your payment after any deductible sources of income have been subtracted from your gross disability payment.

**PART-TIME BASIS** means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

**PAYABLE CLAIM** means a claim for which Unum is liable under the terms of the policy.

**PHYSICIAN** means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

**PLAN** means a line of coverage under the policy.

**PRE-EXISTING CONDITION** means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

**RECURRENT DISABILITY** means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a disability payment.

**REGULAR CARE** means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

**REGULAR OCCUPATION** means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

**RETIREMENT PLAN** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

**SALARY CONTINUATION OR ACCUMULATED SICK LEAVE** means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

**SELF-REPORTED SYMPTOMS** means the manifestations of your condition which you tell your physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

**SICKNESS** means an illness or disease. Disability must begin while you are covered under the plan.

**SURVIVOR, ELIGIBLE** means your spouse, if living; otherwise your children under age 25 equally.

**WAITING PERIOD** means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

**WE**, **US** and **OUR** means Unum Life Insurance Company of America.

**YOU** means an employee who is eligible for Unum coverage.

# ERISA

## Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

**Name of Plan:**
Group Long Term Disability Insurance for Employees of Forest River, Inc.

**Name and Address of Employer:**
Forest River, Inc.
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46515-3030

**Plan Identification Number:**
a. Employer IRS Identification #: 20-3284366
b. Plan #: 510

**Type of Welfare Plan:**
Disability Income

**Type of Administration:**
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

**ERISA Plan Year Ends:**
December 31

**Plan Administrator, Name, Address, and Telephone Number:**
Forest River, Inc.
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46515-3030
(574) 389-4600

Forest River, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

**Agent for Service of Legal Process on the Plan:**
Forest River, Inc.
55470 County Road 1

PO Box 3030
Elkhart, Indiana
46515-3030

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 951840 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

## EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

## EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

## MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for an Employer paid plan;
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or

- the Employer fails to pay any portion of the premium within the 60 day grace period. If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

If Unum cancels or modifies the policy or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

## HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

## CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or 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".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

**YOUR RIGHTS UNDER ERISA**

As a participant in the 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 the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise

discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps 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 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 Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's 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, if, for example, it finds your claim is frivolous.

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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

## OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

**Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018.**

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

## NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

### Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

**Life Insurance**

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

**Health Insurance**

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

**Annuities**

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

**The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**

TRANSAMERICA
Employee Benefits

Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
Home Office: Cedar Rapids, Iowa
*Adminstrative Office:*
1400 Centerview Drive, P.O. Box 8063
Little Rock, Arkansas 72203-8063
Customer Service: (888) 763-7474

October 07, 2021

FOREST RIVER INC
ATTN: DAVID BESINGER
900 CR1 /PO BOX 3030
ELKHART, IN 46544

GROUP NUMBER: G000046683

Welcome to the Transamerica Life Insurance Company family.

Your Master Contract(s) is attached. Please take a moment to review the documents.

Should you have need for any administrative forms, you can find them on our website at www.TransamericaEmployeeBenefits.com.

Should you have any concerns or changes that may need to be made now or in the future, you may contact the following departments(s):

For Billing: 1-866-411-4159 or tebbillingservices@transamerica.com

For Claims or Customer Service: 1-888-763-7474 or tebcustresp@transamerica.com

We look forward to servicing your needs.

Sincerely,

Transamerica Life Insurance Company

TRANSAMERICA®

Revised April 29th, 2019

## NOTICE OF PRIVACY PRACTICES TRANSAMERICA COMPANIES

This Notice is provided to you by the Transamerica companies listed at the end of this Notice. We value our customers and your trust in us, especially when you share your personal information with us. We understand that the privacy and security of that personal information is important to you. We call this information "data". This Notice describes the data we collect and how we use, share and protect such data. The types of data we collect and share depend on the type of product or service you have with us. Also, Transamerica websites' and applications' Terms of Use and Privacy Statements provide additional detail on the treatment and handling of data when interacting with these sites or applications. If your relationship with us ends, we will continue to handle your data in accordance with this Notice.

**Data That We Collect:** We collect the following types of data:

| Data | Typical Data Sources |
|---|---|
| Name, email and physical address, age, social security and driver's license numbers, employment, financial and health data and history. | • You directly, when you submit applications and forms and engage in communications with us<br>• Employers, healthcare providers, other insurance companies and other authorized entities |
| Data about your transactions with us. Data about your transactions with unaffiliated third parties ("Third Parties") that is shared with Transamerica. Transactional data collected as part of your interaction with Transamerica or provided by Third Parties can include , but is not limited to, account balances, accrued benefits, coverages, premiums, payment and claims history, financial transactions, and medical or health data. | • Our affiliates (companies under common ownership)<br>• Third Parties<br>• Transamerica's websites, digital platforms, and applications<br>• Assistive technologies, mobile or wearable devices, or other similar technology |
| Credit history, employment information and other information about your creditworthiness, medical care and health. | • Consumer reporting agencies and other service providers we use such as third party data suppliers<br>• Your employers, healthcare providers, other insurance companies and other authorized entities |
| Data about products and services you obtain or in which you might be interested. | • You<br>• Third Parties with whom we have joint marketing arrangements<br>• Other Third Parties as allowed |
| Data you provide to Third Parties when you have authorized the Third Party to share such data with other parties. This includes data collected through Third Party applications, websites, or other digital interfaces, data you share with us, data you have authorized us to receive, or data you have authorized Third Parties to share with us. | • Third Party applications, websites, or other digital interfaces where you have agreed to share your data<br>• Assistive technologies, mobile or wearable devices, or other similar technology |

**How We Use Your Data:** We use data to provide our services and for purposes allowed by law, this includes use authorized by you. For example, we may use your data to:

- Process claims and transactions,
- Research, develop,and market products and services,
- Prevent and prosecute fraud or criminal activities,
- Maintain your accounts,
- Comply with applicable laws and for security purposes,
- Maintain, operate, and market our business, or
- Support online customer experiences, digital platforms, and/or applications you elect to participate in

**Sharing Data:** We may share your data with Third Parties and affiliates as permitted or required by law, or when you authorize us to do so. In certain situations, our ability to share information is limited by other restrictions, such as certain contractual agreements with plan sponsors or similar arrangements. **We will honor those restrictions to the extent they conflict with the terms of this Notice**.

We may also share your data with Third Parties in certain circumstances, such as:

- Those who provide services to support our business, including processing claims, account maintenance, and marketing and sales,
- Credit bureaus,
- Insurance regulators, law enforcement, governmental authorities and other Third Parties in response to legal process or as required by law,
- Health care professionals, including to verify coverage or to provide information relating to a medical condition,
- Governmental agencies so they can decide if you are eligible for public benefits,
- Other financial companies in connection with joint marketing efforts,

- Other insurance companies (including successor insurers), agents and insurance support organizations to coordinate your benefits or in connection with insurance transactions involving you,
- Group policyholders, for example, regarding claims experience or to support service audits,
- Certificate or policyholders regarding the status of an insurance transaction,
- Those who have a legal or beneficial interest in your assets (such as creditors with a lien on your account),
- Your employer or plan sponsor as needed to support the administration of employee accounts (but only as permitted by law and only if you have established an account in connection with your employer),
- Your representatives and lawyers,
- To prevent and prosecute fraud or criminal activities,
- To conduct actuarial or research studies, and
- In connection with the sale or merger of all or part of our business

Our affiliates include a broad range of companies who provide financial services. These include insurance companies and agencies, and investment advisors. They also include agencies and broker/dealers who may not be included in the scope of this Notice. If we serve you through one of these professionals not covered under the Notice, you may contact them directly for information regarding their privacy practices. Specific contact information for these professionals can be found on your statements and other correspondence from them. We do not share information about your creditworthiness among our affiliates. The Transamerica affiliated companies with whom we may share your other information may include our companies with a Transamerica or Stonebridge name. For example, we may share your data with our affiliates:

- For their everyday business purposes;
- So they can tell you about products and services they offer;
- So they can determine which of their products and services may be of interest to you;
- So they can provide various services to us to support our business, such as claims processing, maintaining your account, and marketing products and services to you; or
- So they can audit themselves or their agents

**Your Choice to Limit Marketing by Transamerica Affiliates:** You may limit our affiliates' use of certain types of data to market their own products and services to you ("Opt Out"). To do this, choose one of the Opt Out methods set forth below. This data relates to your transactions and experiences with us. For example, this may include the products you own and your account history. Your choice to limit marketing offers from our affiliates will apply for at least 5 years from when you Opt Out. Once that period expires, we will send you a renewal Notice. That renewal Notice will allow you to continue to limit marketing offers from our affiliates for at least another 5 years. If you have already Opted Out of marketing offers from our affiliates, you do not need to Opt Out again until you receive a renewal Notice. If you hold a policy or account jointly with someone else, your Opt Out elections will apply to everyone on the account. When you are no longer our customer, we will continue to share your data as described in this Notice (including your Opt Out, if applicable). However, you may contact us at any time to elect to Opt Out.

**To Opt Out:** To limit our sharing of data with affiliates for marketing by affiliates as described above, you may:

- Call us at **877-257-4690** and our menu will prompt you through your choice(s), or
- Visit us online at **www.transamerica.com/optout**

**Your Right of Access and Correction:** You have a right of access and correction with respect to data we collect except data that relates to and is collected in connection with a claim or criminal or civil lawsuit involving you. You must make your request to us in writing listing the account or policy numbers with the data you are requesting to access. If you tell us of an error in the data, we will review it and if we agree, we will correct our records. If we don't agree, you may dispute our findings in writing and send your statement to us. We will include your statement whenever we provide your disputed information to anyone outside Transamerica. This is a summary of your rights. For a copy of our more detailed Notice of Insurance Information Practices as applicable to your product or service, please send a written request to 6400 C St. SW Cedar Rapids, IA 52499-0001.

**Protecting Your Data:** We maintain appropriate controls to limit access to data to persons who need access to it in order to do their jobs or to provide products and services to you. We train our workforce in the proper handling of data. In addition, we maintain other physical, technical, and administrative or procedural safeguards to protect your data.

**Other Privacy Protections for Vermont Residents only.** We will not share data we collect about you with Third Parties, except as permitted by Vermont law or authorized by you. We may still share data about our transactions or experiences with you with our affiliates. **For California Residents only.** If you are a California resident, you will receive a separate notice with additional choices.

We may revise this Notice. If we make material changes, we will notify you as required by law. This Notice is provided by the following Transamerica companies and any separate accounts established for products they offer:

**Transamerica Advisors Life Insurance Company**
**Transamerica Capital, Inc**
**Transamerica Casualty Insurance Company**
**Transamerica Financial Life Insurance Company**
**Transamerica Investors Securities Corporation**
**Transamerica Life Insurance Company**
**Transamerica Premier Life Insurance Company**
**Transamerica Retirement Advisors, LLC**
**Transamerica Retirement Solutions, LLC**
**Stonebridge Benefit Services, Inc**

**NOTICE OF PROTECTION PROVIDED BY THE**
**INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

**Basic Protections Currently Provided by ILHIGA**

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

**Life Insurance**

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

**Health Insurance**

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

**Annuities**

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

**The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**

# IMPORTANT NOTICE

**Questions regarding your policy or coverage should be directed to:**

**Transamerica Life Insurance Company**
**Administrative Office: PO Box 869094, Plano, TX 75086-9817**
**Phone: 1-888-763-7474**

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499
A Stock Company

| | |
|---|---|
| **Policyholder:** | **FOREST RIVER INC** |
| **Policy Number:** | **T200075492** |
| **Policy Effective Date:** | **OCTOBER 1 2021** |
| **Policy Anniversary Date:** | **NOVEMBER 1** |
| **Governing Jurisdiction:** | **INDIANA** |

Transamerica Life Insurance Company ("the Company," "we," "us," and "our") agrees to pay the benefits described in this Policy, subject to all terms, conditions, and limitations, in consideration of:
1. The Policyholder Application, a copy of which is attached to and made a part of this Policy; and
2. The payment of the first premium.

By our acceptance of the first premium paid by the Policyholder ("you," "your," and "yours") and by your receipt of this Policy, you agree:
1. To be bound by the terms of this Policy; and
2. To pay all premiums to us according to the terms of this Policy.

This Policy is subject to the laws of the governing jurisdiction in which it is issued. This is not a policy of workers' compensation insurance.

This Policy is signed for the Company at our Home Office to take effect on the Policy Effective Date.

General Counsel and Secretary

President

# Master Policy for Group Term Life Insurance

**20 Year Term Life Insurance**
**Renewable to Expiration Date**
**Premiums Subject to Change**
**Conversion to Permanent Life Insurance Option**
**Non-Participating – No Dividends**

**Administrative Office**
**PO Box 869094**
**Plano, TX 75086-9817**
**1-888-763-7474**

## Table of Contents


Policy Schedule ..... 3
Definitions ..... 5
Policyholder Provisions
- Duties ..... 6
- Certificates ..... 6
- Inspection of Policy ..... 6
- Notice of Right to Convert Coverage ..... 6
- Notice of Right to Continue Coverage ..... 6

Premiums, Policy Changes, Termination, and Reinstatement
- Premiums ..... 6
- Who May Change This Policy ..... 6
- When Policy Changes are Effective ..... 6
- When This Policy Ends ..... 6
- Grace Period ..... 7
- When Policy May Be Reinstated ..... 7

General Provisions
- Adjustment in the Event of Clerical Error ..... 7
- Adjustment in the Event of Error in Age or Tobacco Use ..... 7
- Entire Contract ..... 7
- Non-Participation ..... 7
- Right to Contest ..... 7
- Time Effective ..... 7

Certificate Provisions Made a Part of This Policy ..... 7

## POLICY SCHEDULE

## ELIGIBILITY REQUIREMENTS

**Employee or Member –** To become an Insured under this Policy:
1. Must be within the Age range of 16 through 65.
2. Must meet the eligibility requirements listed on the Policyholder's Application.
3. Must satisfactorily answer the Evidence of Insurability questions on the Application, if applicable.
4. Must be in Active Service.

**Dependents** (if available) **–** To become an Insured under this Policy:
1. Must meet the definition of a Dependent.
2. Must satisfactorily answer the Evidence of Insurability questions on the Application, if applicable.
3. Must not be eligible as an employee or member under this Policy.

## EVIDENCE OF INSURABILITY

Evidence of Insurability will be required for any person who:
1. Does not apply for this insurance within the first 31 days after first becoming eligible to apply.
2. Applies for an amount of insurance that exceeds the Guaranteed Issue Limit, if applicable.
3. Applies for reinstatement of life insurance coverage after such coverage has been terminated.
4. Converts insurance under this Policy to permanent insurance, and later becomes eligible for coverage under this Policy again.

## EFFECTIVE DATE OF COVERAGE

An eligible employee or member must apply for this insurance on a form approved by us, and agree in writing to pay any required premium contributions. Coverage will become effective on:
1. The Policy Effective Date, for Applications submitted and approved by us prior to the Policy Effective Date. Under no circumstances will coverage be effective prior to the Policy Effective Date.
2. The Certificate Effective Date, for Applications submitted and approved by us after the Policy Effective Date.

Except that:
1. If an employee or member is not in Active Service on the day coverage is scheduled to become effective, coverage will become effective on the date he or she returns to Active Service.
2. If a Dependent is not in Active Service (if employed) or is confined in a hospital (if not employed) on the date his or her coverage is scheduled to become effective, coverage will become effective on the day following his or her return to Active Service or discharge from the hospital.

## BENEFITS

**Employee or Member:**
Increments of $10,000, maximum $500,000, not to exceed five times Salary.

**Dependents:**
Increments of $5,000, maximum $100,000, not to exceed 50% of the employee or member coverage amount.

**Salary** - means the employee's or member's annualized regular wages rounded up to the next highest $1,000. Salary does not include overtime or bonuses, cash awards, expense allowances, shift differential, goal sharing, variable pay, stock option earnings, incentive items or other extra pay items.

## MINIMUM PARTICIPATION REQUIREMENT

A minimum of two eligible employee or members insured is required to issue and keep this Policy in force.

## INCLUDED RIDERS

The following optional riders are available with this Policy:

Accelerated Death Benefit for Terminal Illness Rider
Accelerated Death Benefit for Chronic Condition Rider
Waiver of Premium Due to Layoff or Strike Rider
Child Term Insurance Rider

## ADDITIONAL AGREEMENTS

None

## DEFINITIONS

The provisions of this Policy are subject to the defined terms below.

**Active Service** - The Insured, if an employee, must be:
1. Performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day; and
2. Performing these duties at one of the places of business where he or she normally works or at some location directed by the employer.

The Insured is considered to be in Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her occupation if it were a scheduled work day and he or she were in Active Service on the last preceding regular work day.

For members, the Insured will be in Active Service if he or she meets the eligibility requirements on the Policyholder Application.

**Application** - The form completed and signed by your eligible employees or members to apply for coverage under this Policy.

**Certificate** - The document that describes the terms of the insurance for an insured employee, member or Dependent, as applicable.

**Child** – A Child of the employee or member who is within the Age range of 15 days through Age 25 and is:
1. A natural child;
2. A legally adopted child, or a child for whom adoption proceedings have begun;
3. A stepchild;
4. A child for whom the employee or member has been appointed legal guardian; or
5. A grandchild who lives with and is financially dependent on the employee or member for support.

**Dependent -** An employee's or member's Spouse or Other Adult Dependent or Child.

**Death Benefit** - The amount payable upon the death of an Insured.

**Insured** - The employee or member or Dependent who is covered under this Policy.

**Other Adult Dependent** - The employee's or member's common law marriage partner, domestic partner, or civil union partner, if legally required in the governing jurisdiction or as otherwise agreed upon between you and us, who is within the Age range of 16 through 65.

**Policy** - This document that describes the insurance available to your employees or members.

**Policyholder, you, your,** or **yours** - The entity named on the cover page of this Policy.

**Policyholder Application** - The form completed and signed by you to apply for this Policy

**Spouse** - A person who is legally married to the employee or member, who is within the Age range of 16 through 65.

**Tobacco Use** - The Insured's use of any of the following tobacco products within the last 12 months: cigarettes, cigars, pipes, snuff, and chewing tobacco, or nicotine replacement products, such as patches or gum. Such Insured would be considered a **Tobacco User**.

**We**, **us** and **our** - Transamerica Life Insurance Company.

## POLICYHOLDER PROVISIONS

**Duties -** Your duties will include, but are not limited to, the following:

1. Provide us with any and all information we determine to be necessary for the enrollment of your employees or members for the determination of their eligibility. You must provide us with all data we need to underwrite the coverage, to compute premiums, to maintain necessary administrative records, and to generally administer this Policy.
2. Provide us with the completed Applications (or other forms acceptable to us), if applicable.
3. Fulfill the agreements listed on the Policyholder Application.
4. Maintain records pertaining to the insurance of your employees or members as we may reasonably require while this Policy is in force. For two years after this Policy terminates, you must allow us the opportunity to examine these records at any reasonable time during normal business hours.
5. Cooperate fully with us in preparing and/or delivering any notices to your employees or members regarding this insurance.

**Certificates -** We will issue Certificates for each Insured. The Certificates will describe the life insurance coverage provided by this Policy.

**Inspection of Policy -** You must make this Policy available for inspection by your employees or members at all reasonable times during normal business hours.

**Notice of Right to Convert Coverage -** You are required to give each Insured a notice of the right to convert coverage after an Insured ceases to be eligible for coverage under this Policy. Details are set forth in the Conversion Option section of the Certificate.

**Notice of Right to Continue Coverage -** You are required to give each Insured a notice of the right to continue coverage after an Insured ceases to be eligible for coverage under this Policy. Details are set forth in the Portability Option of the Certificate.

## PREMIUMS, POLICY CHANGES, TERMINATION, AND REINSTATEMENT

**Premiums –** The premiums due will be the sum of the premiums due for all Insureds under this Policy. Premiums are due and payable to us by you on each premium due date. The first premium due date is the Policy Effective Date. Later premiums are due monthly.

The amount of the premium for each Insured is shown on his or her Certificate Schedule.

**Who May Change This Policy -** The terms of this Policy, including premium rates, may be changed at any time by written agreement between you and us. The insurance provided by this Policy may be changed or canceled without the consent of any Insured and without prior notice to any Insured. Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to this Policy and then only in writing. No agent or Policyholder has authority to change this Policy or to waive any of its provisions. All changes are subject to the laws of the governing jurisdiction.

**When Policy Changes are Effective -** Unless otherwise agreed upon in writing, the Effective Date of any change in premium or benefits will be the Policy Anniversary Date.

**When This Policy Ends** – This Policy will terminate at the earliest of the following events:

1. If any premium payable is not paid within its Grace Period, this Policy will terminate on the day after the end of the Grace Period;
2. If you submit a 60-day advance written request to us to terminate the Policy, this Policy will terminate on the date specified in such request;
3. If we give you a 60-day advance written notice that we intend to terminate the Policy, this Policy will terminate on the date specified in such notice;
4. If you fail to comply with any terms of the Policy, or fail to fulfill any obligations under or pertaining to this insurance, or fail to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to this insurance, this Policy will terminate on the 32nd day after we have given you written notice of our intent to terminate.

Termination of this Policy is without prejudice to claims that occur or commence prior to the date of termination.

**Grace Period** – You have a Grace Period of 31 days from each premium due date, except the first, in which to pay the premium then due. Coverage will continue during the Grace Period. You are liable for the premium during the Grace Period.

**When Policy May Be Reinstated** – At our sole discretion, we may reinstate the Policy which has terminated if requested to do so by the Policyholder.

## GENERAL PROVISIONS

**Adjustments in the Event of Clerical Error -** Clerical error will not void insurance otherwise validly in force; nor will it continue or make insurance valid that otherwise would cease or would never have been issued.

**Adjustments in the Event of Error in Age or Tobacco Use -** If the Age or Tobacco Use status of any Insured is misstated on the Application, we will adjust the Death Benefit to reflect the amount that the most recent premium would buy at the Insured's correct Age or Tobacco Use status.

**Entire Contract -** This Policy, your Policyholder Application, a Certificate evidencing the insurance made available to your employees or members, and any riders, endorsements and amendments constitute the entire contract of insurance.

**Non-Participation -** This is non-participating insurance. Neither you nor any employee or member participates in our profits or surplus.

**Right to Contest** - We will not use any statement, except fraudulent statements, to void or reduce benefits under this Policy or any Certificate after it has been in force for two years from its Effective Date. Any such statement would have to be in a signed form. This also applies to all Riders.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you or your representative.

**Time Effective -** For any dates used in this Policy, the effective time will be 12:01 AM at your address.

## CERTIFICATE PROVISIONS MADE A PART OF THIS POLICY

The remainder of this Policy consists of the provisions that appear in the Certificate (including any Riders and/or Endorsements) that describes the insurance made available to your employees or members under this Policy. Copies of the Certificate, any Riders and Endorsements, if any, are attached to and become a part of this Policy.

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499
A Stock Company

**FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 1-888-763-7474**
**PLEASE READ YOUR CERTIFICATE CAREFULLY**

## GROUP TERM LIFE INSURANCE CERTIFICATE

This Certificate summarizes the Master Policy for Group Term Life Insurance ("Policy") that is underwritten by Transamerica Life Insurance Company (the "Insurer"). Read it carefully to become familiar with your coverage.

Terms important to understanding this Certificate are defined in the **Definitions** section or in separate Certificate Provisions and are capitalized in this Certificate.

The Policy under which this Certificate is issued may be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Owner or Insured. Premiums are subject to periodic changes.

### RIGHT TO EXAMINE AND RETURN CERTIFICATE WITHIN 30 DAYS

**AT ANY TIME WITHIN 30 DAYS AFTER YOU RECEIVE THIS CERTIFICATE, YOU MAY RETURN IT TO US OR THE GROUP POLICYHOLDER. WE WILL CANCEL THIS CERTIFICATE AND VOID IT FROM THE BEGINNING. WE WILL REFUND TO YOU ANY PREMIUMS PAID.**

This Certificate is signed for the Company at our Home Office to take effect on its Effective Date.

General Counsel and Secretary

President

## Group Term Life Insurance Certificate

**20 Year Term Life Insurance**
**Renewable to Expiration Date**
**Premiums Subject to Change**
**Conversion to Permanent Life Insurance Option**
**Non-Participating – No Dividends**


**Administrative Office**
PO Box 869094
Plano, TX 75086-9817
**1-(888) 763-7474**
**E-Mail Address: customer service@Transamerica.com**
**Web Address: www.transamericaworksite.com**

## TABLE OF CONTENTS


**CERTIFICATE SECTIONS** **PAGE**

Right to Examine and Return Certificate ..... 1
Certificate Schedule ..... 3
Table of Maximum Annual Premium Rates ..... 4
Definitions ..... 5
Ownership ..... 6
Beneficiary ..... 6
Death Benefit ..... 6
Renewal Provision ..... 7
Effective Date ..... 7
Premiums ..... 7
Termination ..... 7
Reinstatement ..... 7
Conversion Option ..... 7
Portability Option ..... 8
General Provisions
- Assignment ..... 8
- Claims Procedure ..... 8
- Entire Contract ..... 8
- Grace Period ..... 8
- Policyholder as Your Agent ..... 8
- Misstatement of Age or Tobacco Use Status ..... 8
- Right to Contest ..... 8
- Suicide Exclusion ..... 8
- When Notice is to be Given by Us ..... 8

## CERTIFICATE SCHEDULE

| | | | |
|---|---|---|---|
| POLICYHOLDER | FOREST RIVER INC | POLICY NUMBER | T200075492 |
| INSURED | XXXX XXX | CERTIFICATE NUMBER | XXXXX |
| DEATH BENEFIT | $XX,XXX | EFFECTIVE DATE | XXXXXX |
| CLASS OF RISK | [TOBACCO] | PREMIUM PAYMENT | $XX.XX MONTHLY |
| INSURED ISSUE AGE | XX | INITIAL TERM PERIOD | 20 Year Term |
| EXPIRATION DATE | Certificate Anniversary Date following Insured's 100th Birthday | | |
| OWNER | [THE INSURED] | | |

### RIDERS INCLUDED IN YOUR COVERAGE

Accelerated Death Benefit for Terminal Illness Rider
Maximum Benefit: the lesser of: (a) up to 50% of the Insured's Death Benefit; or (b) $100,000
Monthly Premium: $0.00

Waiver of Premium Due to Layoff or Strike Rider
Benefits Stop on the Certificate Anniversary Date following the Insured's 65th birthday
Monthly Premium: Included

Accelerated Death Benefit for Chronic Condition Rider $XX.XX
Percentage of death benefit amount for monthly benefit: 4%
Percentage of death benefit amount for one-time lump sum benefit: 20%
Elimination Period: 90 Days
Maximum Monthly Premium Rate per $1,000: $X.XXXX

Child Term Insurance Rider:
Death Benefit: Each Child: $XX,XXX
Monthly Premium: $X.XX

## TABLE OF MAXIMUM ANNUAL PREMIUM RATES

The maximum annual premium for this Certificate will be determined by multiplying the annual rate per $1,000 by the number of $1,000's of Death Benefit amount. These rates do not include the additional premiums payable for any Riders which may be attached to this Certificate. These are annual rates and should be adjusted for other payment methods or modes. Current rates lower than these maximum rates may be charged.

| ATTAINED AGE | NON-TOBACCO 20 YEAR TERM* ANNUAL RATE PER $1,000 | TOBACCO 20 YEAR TERM * ANNUAL RATE PER $1,000 | ATTAINED AGE | NON-TOBACCO 20 YEAR TERM* ANNUAL RATE PER $1,000 | TOBACCO 20 YEAR TERM * ANNUAL RATE PER $1,000 |
|---|---|---|---|---|---|
| 16 | $ 3.57 | $ 4.52 | 58 | $ 21.52 | $ 32.68 |
| 17 | $ 3.57 | $ 4.52 | 59 | $ 22.90 | $ 34.42 |
| 18 | $ 3.57 | $ 4.52 | 60 | $ 24.50 | $ 37.23 |
| 19 | $ 3.57 | $ 4.52 | 61 | $ 26.39 | $ 39.76 |
| 20 | $ 3.57 | $ 4.52 | 62 | $ 28.23 | $ 42.82 |
| 21 | $ 3.57 | $ 4.52 | 63 | $ 30.13 | $ 46.96 |
| 22 | $ 3.57 | $ 4.52 | 64 | $ 33.47 | $ 51.57 |
| 23 | $ 3.57 | $ 4.52 | 65 | $ 37.08 | $ 58.57 |
| 24 | $ 3.77 | $ 4.62 | 66 | $ 40.39 | $ 66.32 |
| 25 | $ 3.77 | $ 4.62 | 67 | $ 43.95 | $ 72.03 |
| 26 | $ 4.00 | $ 4.85 | 68 | $ 47.96 | $ 77.20 |
| 27 | $ 4.00 | $ 4.85 | 69 | $ 52.30 | $ 83.01 |
| 28 | $ 4.24 | $ 5.09 | 70 | $ 67.73 | $ 98.08 |
| 29 | $ 4.24 | $ 5.09 | 71 | $ 74.57 | $ 109.25 |
| 30 | $ 4.53 | $ 5.35 | 72 | $ 81.66 | $ 123.01 |
| 31 | $ 4.53 | $ 5.35 | 73 | $ 95.10 | $ 136.86 |
| 32 | $ 4.85 | $ 5.62 | 74 | $ 112.08 | $ 153.03 |
| 33 | $ 4.85 | $ 5.62 | 75 | $ 136.35 | $ 183.21 |
| 34 | $ 5.19 | $ 5.90 | 76 | $ 149.43 | $ 203.95 |
| 35 | $ 5.42 | $ 6.27 | 77 | $ 163.59 | $ 225.72 |
| 36 | $ 5.79 | $ 6.87 | 78 | $ 179.42 | $ 248.38 |
| 37 | $ 6.18 | $ 7.63 | 79 | $ 196.27 | $ 272.66 |
| 38 | $ 6.42 | $ 7.78 | 80 | $ 224.67 | $ 299.57 |
| 39 | $ 6.42 | $ 7.91 | 81 | $ 262.78 | $ 329.97 |
| 40 | $ 6.58 | $ 7.99 | 82 | $ 306.89 | $ 364.70 |
| 41 | $ 6.91 | $ 9.09 | 83 | $ 348.89 | $ 404.10 |
| 42 | $ 7.47 | $ 9.89 | 84 | $ 386.65 | $ 450.37 |
| 43 | $ 8.04 | $ 10.92 | 85 | $ 429.20 | $ 496.61 |
| 44 | $ 8.72 | $ 11.64 | 86 | $ 467.79 | $ 549.13 |
| 45 | $ 8.72 | $ 12.67 | 87 | $ 525.89 | $ 599.72 |
| 46 | $ 9.17 | $ 13.54 | 88 | $ 586.58 | $ 656.92 |
| 47 | $ 9.36 | $ 14.60 | 89 | $ 651.28 | $ 711.28 |
| 48 | $ 9.55 | $ 15.56 | 90 | $ 710.91 | $ 773.90 |
| 49 | $ 9.74 | $ 16.94 | 91 | $ 741.08 | $ 840.64 |
| 50 | $ 10.95 | $ 18.22 | 92 | $ 800.41 | $ 913.47 |
| 51 | $ 12.16 | $ 19.50 | 93 | $ 888.45 | $ 960.00 |
| 52 | $ 13.59 | $ 20.95 | 94 | $ 960.00 | $ 960.00 |
| 53 | $ 15.04 | $ 22.65 | 95 | $ 960.00 | $ 960.00 |
| 54 | $ 16.62 | $ 24.37 | 96 | $ 960.00 | $ 960.00 |
| 55 | $ 16.69 | $ 26.18 | 97 | $ 960.00 | $ 960.00 |
| 56 | $ 18.49 | $ 28.47 | 98 | $ 960.00 | $ 960.00 |
| 57 | $ 20.22 | $ 30.99 | 99 | $ 960.00 | $ 960.00 |

* Current premiums are guaranteed for the first 5 Certificate years.

## DEFINITIONS

**Active Service** - The Insured, if an employee, must be:
1. Performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day; and
2. Performing these duties at one of the places of business where he or she normally works or at some location directed by the employer.

The Insured is considered to be in Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her occupation if it were a scheduled work day and he or she were in Active Service on the last preceding regular work day.

For members, the Insured will be in Active Service if he or she meets the eligibility requirements on the Policyholder Application.

**Age** or **Attained Age** - The Insured's Age as of the last Certificate Anniversary Date. Attained Age will increase by one year on each Certificate Anniversary Date. **Issue Age** is the Attained Age of the Insured as of the Effective Date. The Issue Age is shown on the Certificate Schedule.

**Amendment, Endorsement,** or **Rider** - Any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provisions or benefits.

**Anniversary Date** – The month and date of each calendar year that is the same month and date as the Effective Date.

**Application** - The form completed and signed by the Owner to apply for this life insurance coverage.

**Beneficiary** - The recipient of the Death Benefit of this Certificate in the event of the Insured's death.

**Certificate** – This document that describes your insurance coverage.

**Death Benefit -** The amount payable upon the Insured's death.

**Effective Date** - The date when the Policy or this Certificate takes effect as shown on the Policy Schedule or Certificate Schedule.

**Expiration Date –** The date that coverage under this Certificate terminates if the Insured is living on that date.

**Grace Period** – The Grace Period is a 31-day period after a premium payment is due. See the Grace Period provision in the General Provisions section for details.

**Insured** - The person covered under this Certificate and named on the Certificate Schedule.

**Initial Term Period –** The number of years for which the Policy is initially issued.

**Lapse** - The termination of this Certificate for the nonpayment of premium or insufficient payment of the premium due.

**Owner, you, your,** or **yours** - The employee or member named as Owner on the Certificate Schedule to which this Certificate is issued.

**Policy** – The document that is issued to the Policyholder.

**Policyholder** – The group entity named on the cover page of the Policy.

**Reinstate**, **Reinstated,** or **Reinstatement** - To restore coverage if this Certificate has Lapsed, subject to the Reinstatement provision.

**Tobacco Use** – The Insured's use of any of the following tobacco products within the last 12 months: cigarettes, cigars, pipes, snuff, and chewing tobacco, or nicotine replacement products such as patches or gum. Such Insured would be considered a **Tobacco User**.

**Transamerica Life Insurance Company, the Company, we, us,** or **our** – The Insurer that underwrites this life insurance coverage and pays the benefits upon a claim.

## OWNERSHIP

You have certain rights while the Insured is living and this Certificate is in force. Your rights include, but are not limited to, those listed below:

1. Changing the Beneficiary, subject to any irrevocable Beneficiary that may have been named (an irrevocable Beneficiary cannot be changed without the written consent of that irrevocable Beneficiary);
2. Assigning any right or benefit under this Certificate;
3. Reinstating coverage that has Lapsed, subject to the Reinstatement provision;
4. Exercising an option under any Rider attached to this Certificate; and
5. Transferring ownership. Any requested change of ownership must be in writing on our form and approved by us. Your requested change will be effective on the date that you signed it, subject to any actions taken prior to receipt of such change.

If you, as the Owner, are not the Insured, and you die before the Insured, the executor or administrator of your estate will have these rights.

## BENEFICIARY

**Payment of the Death Benefit** - If the Insured dies while this Certificate is in force, we will pay the Death Benefit to the Beneficiary, subject to the provisions of this Certificate. The Beneficiary will be as designated on the Application for this insurance coverage, unless later changed as provided under the How to Change the Beneficiary provision.

**If a Beneficiary is Not Named in the Application or the Stated Beneficiary Dies** - The rights of any Beneficiary to receive the Death Benefit will end if the Beneficiary dies prior to the death of the Insured. Except to the degree that benefits have already been paid, and unless otherwise provided, the rights of any Beneficiary who dies at the time of, or within 30 days after, the Insured's death will end at their death. If the rights of all named Beneficiaries have ended, or if a Beneficiary was not named in the original Application, benefits will be payable to the Insured's survivors in the following order of preference:

1. Spouse or Other Adult Dependent;
2. Child(ren) (in equal amounts);
3. Parents (in equal amounts);
4. Siblings (in equal amounts);
5. The executor or administrator of the Owner's estate.

The existence of multiple Beneficiaries will not increase the benefit payable.

**Protection of the Death Benefit** - To the extent permitted by law, the Death Benefit will not be subject to the claims of the Beneficiary's creditors or to any legal process against the Beneficiary.

**How to Change the Beneficiary** - You may change the Beneficiary at any time while the Insured is living. Please request a Change of Beneficiary form from us. To be effective, the change must be in writing and signed by both you and a disinterested witness. The change will be effective on the date it is recorded. However, any benefits paid before we receive the notice of a change in Beneficiary will not be subject to such change. If the Insured dies after you changed the Beneficiary, but before the date it is recorded, the change will be effective on the date you signed the valid change request.

## DEATH BENEFIT

The Death Benefit payable at the Insured’s death will be:

1. The Death Benefit in effect at the Insured’s death; plus
2. Any insurance on the Insured’s life provided by Riders, if any; less
3. Any premium which is due and unpaid for a period from the premium due date to the end of the Certificate month in which the Insured’s death occurs.

**Death Benefit -** The Death Benefit is the amount shown on the Certificate Schedule.

**Refund of Unearned Premium -** We will refund any unearned life insurance premium upon the death of the Insured. Such refund will be made to the designated Beneficiary and will be included with the Death Benefit.

## RENEWAL PROVISION

The Initial Term Period will be for the number of years shown on the Certificate Schedule. After the Initial Term Period, you may renew this Certificate for successive term periods. The successive term periods will be for the same number of years as the Initial Term Period or the period ending at the Expiration Date, if earlier. No evidence of insurability is required on renewal. Renewal will automatically take place on each Policy Anniversary on or following the end of a Term Period provided:

1. The Policy and this Certificate are in force with no premium in default; and
2. The premium due on the Policy Anniversary is paid within the Grace Period.

Upon payment of such renewal premium, any Riders which are part of this Certificate may be continued on renewal of this Certificate, subject to their termination provisions.

## EFFECTIVE DATE

The insurance under this Certificate will start on the Certificate Effective Date if:

1. Your Application has been approved by us on or before this date;
2. The Insured is living; and
3. The initial premium payment has been received by us.

If the Insured is not in Active Service (if employed) or is confined in a hospital (if not employed) on the Certificate Effective Date, then coverage will not become effective until the day after the Insured returns to Active Service or is discharged from the hospital.

## PREMIUMS

**Premium Payments** – The premium payable for this Certificate is shown on the Certificate Schedule. The first premium must be paid on or before the Certificate Effective Date. Premiums are payable in advance of the period to which they apply. All premiums are payable to our Administrative Office or to an agent authorized by us to collect premiums.

**Change of Premium –** We reserve the right to decrease or increase the current premiums after the period of time shown on the Certificate Schedule. However, premiums will never exceed the maximum guaranteed premiums shown on the Certificate Schedule. We will notify you at least 31 days prior to the date a change in premium amount is effective. We will send you a notice of your new current premium.

## TERMINATION

The insurance under this Certificate will stop on the earliest one of these occurrences:

1. The date we receive your written request to terminate coverage;
2. The Expiration Date;
3. The date the Insured dies;
4. The date this Certificate Lapses, subject to the Grace Period; or
5. The date the Policy terminates, subject to the Portability Option.

## REINSTATEMENT

This Certificate may be Reinstated within five years after default in payment. Reinstatement is subject to:

1. Proof of insurability satisfactory to us; and
2. Payment of past due premiums with interest compounded annually at 6% per year.

The Right to Contest provision applies from the effective date of Reinstatement. If this Certificate has been in force for two years during the lifetime of the Insured, it is contestable only as to statements made in the Reinstatement Application.

## CONVERSION OPTION

You can convert the Insured's coverage to permanent life insurance on a policy form that we then issue, without any optional Riders, in an amount not to exceed the amount of insurance that is terminating under the Policy. The premium for the permanent coverage will be based upon the Insured's Attained Age and class of risk at the time of conversion, together with the form and amount of insurance chosen. No evidence of insurability will be required.

We must receive the conversion application and any required premium within 31 days of termination under the Policy. If the Insured dies within the 31-day conversion period, benefits under the Policy will be paid as if coverage had continued, regardless of whether or not the Owner applied for conversion coverage.

Conversion is not available if termination is the result of submitting a fraudulent claim.

## PORTABILITY OPTION

If you lose eligibility for this insurance for any reason other than nonpayment of premiums and while the Policy is still in force, you will have the option to continue this Certificate (including any Riders) by paying the premiums directly to us at our Administrative Office. We will bill you for these premiums. The premiums you pay directly to us may include an additional charge for administrative costs.

Premiums may be paid annually, semi-annually, quarterly or monthly, subject to our rules as of the date you request portability. The Owner may change the frequency of premium payments, subject to our rules in effect at the time of the change by filing a written request at our Administrative Office. If you stop paying the premiums under this option, this Certificate (and any Riders) will cease, subject to the terms of the Grace Period.

## GENERAL PROVISIONS

**Assignment** - If you file an assignment with us and it is recorded at our Administrative Office, your rights and the rights of the Beneficiary will be subject to that assignment.

**Claims Procedure** - Due proof of the Insured's death must be submitted to us at our Administrative Office. The Beneficiary or a personal representative can get a claim form by calling our toll-free telephone number listed on the cover page.

**Entire Contract -** The Policy, the Policyholder Application, this Certificate, your Application and any Riders, Endorsements and Amendments form the entire contract of insurance. All statements made by or for an Insured, in the absence of fraud, will be considered representations and not warranties. We will not use any statement made by or for an Insured to contest this insurance unless:

1. That statement is in writing;
2. That statement has been signed by, or on behalf of, the Insured; and
3. A copy of that statement has been given to the Insured, his or her Beneficiary or personal representative.

Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy, this Certificate, or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

**Grace Period** – If we do not receive a premium payment when it is due, a Grace Period of 31 days will be provided. Written notice will be sent to your last known address on record at least 31 days prior to termination. If a premium payment is not paid by the end of the Grace Period, this Certificate will terminate. If the Insured dies during the Grace Period, we will pay the Death Benefit, less any unpaid premium.

**Policyholder as Your Agent -** For all purposes related to this insurance, your Policyholder serves as your agent and not as our agent.

**Misstatement of Age or Tobacco Use Status** - If the Insured's Age or Tobacco Use status was misstated on the Application for this insurance coverage, we will adjust the Death Benefit to the amount that the most recent premium would buy at the Insured's correct Age or Tobacco Use status.

**Right To Contest -** We will not contest this insurance, in the absence of fraud, after it has been in force during the lifetime of an Insured for two years from the date it starts, except for nonpayment of premiums.

**Suicide Exclusion -** We will not pay a Death Benefit if an Insured dies by suicide, while sane or insane, within two years of the date his or her insurance starts. If the Insured dies by suicide within this two-year period, we will refund the premiums paid for the insurance.

**When Notice is to be Given by Us -** Any notice to be given by us will be sent to the Owner at the Owner's last known address and any assignee of record at the assignee's last known address.

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: PO Box 869094 Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

## CHILD TERM INSURANCE RIDER

This Rider is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail. This Rider has no cash value.

## DEFINITIONS

In addition to the definitions contained in the Contract, the following definition applies to this Rider;

**Insured Child -** A Child of the Insured who is within the Age range of 15 days through Age 25 and is:
1. A natural child;
2. A legally adopted child, or a child for whom adoption proceedings have begun;
3. A stepchild; or
4. A child for whom the employee or member has been appointed legal guardian.

To become an Insured Child after the date of the Application, a child must meet the above definition and the Insured must complete an Application to add the new child as an Insured Child.

## BENEFIT

We agree to pay the Rider Death Benefit to the Beneficiary when we receive due proof that an Insured Child died on or before the Expiry Date of this Rider. The Rider Death Benefit with respect to each Insured Child is shown on the Certificate Schedule.

## GENERAL RIDER PROVISIONS

**Contestability** – This Rider will be contestable on the same basis as the contract, during the lifetime of the Insured, for two years from the Rider Effective Date.

**Suicide** – The Suicide provision in the Contract does not apply to this Rider.

## PREMIUM

The premium for this Rider is shown on the Certificate Schedule.

## EFFECTIVE DATE

The Rider Effective Date is the same date as the contract Effective Date unless we inform the Owner in writing of a different date.

## TERMINATION

**Expiry Date** - Is the Certificate Anniversary after the last Insured Child covered under this Rider has reached his or her 26th birthday.

**Termination** - The term insurance on an Insured Child will terminate on the earliest of the following dates:
1. The date the contract terminates, subject to the Conversion Options of this Rider;
2. The date this Rider or the contract Lapses for failure to pay premium, subject to the Grace Period of the contract.
3. The date the Owner requests termination.
4. The Certificate Anniversary following the date the Insured Child is no longer eligible as a dependent child.
5. The Expiry Date of this Rider.

Our acceptance of a premium for any period after the date of termination of this Rider will create no liability for us, nor will it constitute a waiver of the termination. Any such premium will be returned.

Termination will not affect any claim which occurred prior to termination.

## CONVERSION OPTIONS

**Conversion and Transfer of Ownership due to Death of Owner -** If the Owner dies while this Rider is in force, the premium and deduction will be waived and coverage on any Insured Child under this Rider will automatically be changed to paid-up insurance. This paid-up insurance will have no cash or loan values and will automatically terminate on each Insured Child's 26th birthday. The Owner of the paid-up insurance will be the Insured Child unless such Insured Child is a minor, in which case Ownership will pass to the executor or administrator of the Insured Child's estate for disposition.

**Conversion to Individual Policy** - When the coverage of an Insured Child terminates for any reason other than the non-payment of premium, the Insured Child may convert this Rider to permanent life insurance on a policy form that we then issue, without any riders, for the then current rates and limits, without further evidence of insurability. The following conditions must be met in order for Conversion to occur:

1. We must receive the conversion application and any required premium at our Administrative Office within 31 days of the termination or expiry of coverage under this Rider.
2. Coverage under the new policy will become effective on the date such Application is made and the premium is paid.
3. The amount of insurance under the new policy may be increased to the lesser of:
   a. Five times the Rider Face Amount at the termination date, or
   b. $50,000.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

## ACCELERATED DEATH BENEFIT FOR CHRONIC CONDITION RIDER

**(Living Benefit Rider)**

The Death Benefit will be reduced if any Accelerated Death Benefit is paid.

### SPECIAL NOTICE

Benefits received under this Rider may be taxable as income. Whether any tax liability is incurred when benefits are paid under this Rider could depend on whether your employer has paid the premium, and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult an independent tax advisor to evaluate any tax impact of this benefit.

Receipt of an Accelerated Death Benefit may adversely affect eligibility for Medicaid or other government benefits or entitlements. Without exercising this option, the mere fact that this Rider is part of your contract will not, in and of itself, affect the eligibility for these government programs. However, exercising this option before you apply for these programs, or while you are receiving government benefits, may affect your continued eligibility. Contact the Medicaid Unit of the local Department of Public Welfare and/or the Social Security Administration Office for more information.

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider will apply to this Rider. This Rider has no cash value.

## NOTICE TO YOU, THE OWNER

**FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 1-888-763-7474**

This Rider is not long term care insurance and does not provide long term care insurance, nor is it intended to replace long term care insurance coverage. We advise you to review carefully all limitations of this Rider, as well as those of the contract to which it is attached.

## DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

**Activities of Daily Living –** For the purposes of this Rider, each of the following activities is considered an Activity of Daily Living:

**Bathing -** The Insured's ability to wash himself or herself by sponge bath; or in a tub or shower, including the task of getting into and out of the tub or shower.

**Continence –** The Insured's ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

**Dressing -** The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

**Eating -** The Insured's ability to feed himself or herself by getting food into his or her body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

**Toileting –** The Insured's ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.

**Transferring -** The Insured's ability to move into or out of a bed, chair or wheelchair.

**Chronic Condition –**

1. The inability, expected to be permanent, to perform, without Substantial Human Assistance, at least two Activities of Daily Living for a period of at least 90 days; **or**
2. Severe Cognitive Impairment that is expected to be permanent and that requires Substantial Supervision to protect the Insured from threats to his or her health and safety.

**Death Benefit Amount –** The amount of the Death Benefit in effect on the date immediately following the date the Insured first satisfies the Eligibility for Benefits provision.

**Elimination Period –** The number of consecutive days during which the Insured must meet the Eligibility for Benefits requirements listed under the Benefits provision. During the Elimination Period no benefits are payable under this Rider. The Elimination Period starts on the day the Insured's Chronic Condition begins, as stated in a Physician's certification. The Elimination Period for this Rider is shown in the Certificate Schedule. The Elimination Period needs to be satisfied only once during the Insured's lifetime.

**Immediate Family Member –** Anyone related to an Insured in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or the spouse of any of these. The term "spouse" includes a common law marriage partner, domestic partner, or civil union partner, if legally recognized in the governing jurisdiction.

**Medicare –** The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**Physician –**
1. A doctor of medicine or osteopathy as set forth in Section 1861(r)(1) of the Social Security Act, as amended, who is legally authorized to practice medicine and surgery within the United States by the jurisdiction in which he or she performs such function or action; and
2. Is not an Immediate Family Member.

**Severe Cognitive Impairment –** A severe loss or deterioration in intellectual capacity that is comparable to and includes advanced Alzheimer's disease and is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in the Insured's:
1. short-term or long-term memory;
2. orientation as to person, place and time;
3. deductive or abstract reasoning; or
4. judgment as it relates to safety awareness.

The evaluation shall include utilizing cognitive tests with resulting scores consistent with a diagnosis of Severe Cognitive Impairment.

**Substantial Human Assistance –** Actual hands-on assistance by another individual.

**Substantial Supervision –** Continuous supervision, including but not limited to verbal cueing, by another individual to protect the Insured from harming himself, herself or others, or from threats to the Insured's health and safety.

## BENEFITS

**Eligibility for Benefits –** We will pay an Accelerated Death Benefit under this Rider after we receive written proof of loss that the Insured has met ***all*** of the following conditions:
1. A Physician has certified that the Insured has a Chronic Condition;
2. The Insured has satisfied the Elimination Period; and
3. The contract to which this Rider is attached is in force.

**Accelerated Death Benefit Options**
You may choose one of the following options for submitting a claim for an Accelerated Death Benefit under this Rider:

**Option 1 – Monthly Accelerated Death Benefit –** You may request a monthly Accelerated Death Benefit equal to the applicable percentage of the Death Benefit Amount shown on the Certificate Schedule. This benefit is payable for each month the Insured satisfies the Eligibility for Benefits provision while this Rider is in force. After submitting satisfactory proof of loss, in order to continue receiving the monthly benefit you must provide, every 90 days, a written certification by a Physician that the Insured continues to have a Chronic Condition.

**Option 2 - One-Time Lump Sum Accelerated Death Benefit –** In lieu of the monthly Accelerated Death Benefit, you may request a one-time lump sum Accelerated Death Benefit payment equal to the applicable percentage shown on the Certificate Schedule of the Death Benefit Amount. Upon payment of this lump sum benefit, your rights under this Rider will end and this Rider will terminate.

**Waiver of Monthly Premium –** We will waive the monthly premium for each contract month or partial contract month that you receive benefits under this Rider. If you elect the one-time lump sum Accelerated Death Benefit option, this waiver provision will not apply.

**Concurrent and/or Subsequent Chronic Conditions**
If the Insured suffers from more than one Chronic Condition, we will pay an Accelerated Death Benefit under this Rider for only one of the conditions. Under no circumstances will we pay an Accelerated Death Benefit for any subsequent Chronic Condition under this rider.

A separate claim must be submitted for consideration under any other Accelerated Death Benefit Rider attached to the contract.

Payment of an Accelerated Death Benefit under this Rider will not reduce any Accidental Death benefit available under the contract.

## EFFECT ON INSURED'S DEATH BENEFIT

If the Owner receives Accelerated Death Benefit payments in accordance with this Rider, we will deduct any amounts paid under this Rider from the Death Benefit. The Beneficiary will receive any remaining amount of the Death Benefit after the Insured dies, provided the contract has not terminated. However, if the entire Death Benefit proceeds are paid under the terms of this Rider prior to the Insured's death, the Contract will terminate and there will be no Death Benefit payable upon the Insured's death.

The Death Benefit will be reduced by the amount of the Accelerated Death Benefit.

If you elect monthly Accelerated Death Benefit payments under this Rider, the following conditions will apply during the period that such payments are being made.
1. You cannot change the Death Benefit of the Contract, or add any Riders.
2. We will not accept any premium payments.

If monthly Accelerated Death Benefit payments are made, we will provide a monthly report that shows the effect each benefit payment has on the Death Benefit.

## EXCLUSIONS AND LIMITATIONS

We will **not** pay Rider benefits if the Insured meets the requirements of the Eligibility for Benefits provision as a result of:
1. An intentionally self-inflicted injury or attempted suicide.
2. War or any act of war, declared or undeclared, or service in the armed forces of any country.
3. The Insured's alcohol, drug or other chemical dependence, except if the drug dependency is for a drug prescribed by a Physician in the course of treatment for an injury or sickness.
4. The Insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the Insured's involvement in an illegal activity.

## CLAIMS

The following Claims Procedures apply to this Rider.

**Notice of Claim –** Written notice of claim must be given to us at our Administrative Office or to our agent. Such notice of claim should be made within 30 days after a Physician determines the Insured has a Chronic Condition. If it is not reasonably possible to give notice of claim within that time, the claim may not be denied or reduced due to the delay, so long as notice of claim is given as soon as reasonably possible.

**Claim Forms –** Claim forms should be used for filing proof of loss. We will send such form to the claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, you can give proof of loss in writing, setting forth the nature and extent of the loss within the time stated in the proof of loss provision. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page of the contract. Such initial notice of claim and ongoing written proof of loss must be sent within the time limit stated in the following paragraph.

**Proof of Loss –** Due written proof of loss must be given to us at our Administrative Office. We must receive the initial proof of loss within 90 days after the expiration of the Elimination Period.

Failure to furnish such proof of loss within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof of loss and it was furnished as soon as reasonably possible. In any event, the proof of loss required must be given no later than one year from the time proof of loss is otherwise required, unless the claimant was legally incapacitated.

If you submit a claim under the Monthly Accelerated Death Benefit option, we will require subsequent proof of loss to be submitted periodically after the Insured satisfies the Eligibility for Benefits provision. This means submitting, every 90 days, certification by a Physician that the Insured continues to have a Chronic Condition.

**Physical Examinations –** We have the right to have an Insured examined by a Physician of our choice as often as reasonably necessary while a claim is pending. We will pay for such examination.

**Time of Payment of Claims –** Benefits for a covered loss will be paid as soon as we receive due written proof of loss.

**Payment of Claims –** Benefits are payable to the Owner or a payee designated by the Owner.

**Legal Actions -** No legal action may be brought to recover under the contract within 60 days after written proof of loss has been provided to us as required nor more than three years from the time written proof of loss is required to be furnished.

## GENERAL RIDER PROVISIONS

**Consent For Benefit Payment –** If there is an assignment of this contract on record or an irrevocable Beneficiary on record, we must obtain the consent of any assignee or irrevocable Beneficiary before any Rider benefit is paid.

**Contestability –** This Rider will be contestable on the same basis as the contract, during the lifetime of the Insured, for two years from the Rider Effective Date.

**Suicide –** If the Insured dies by suicide, while sane or insane, within two years from the Rider Effective Date, any premiums refunded under the Suicide Exclusion provision of the contract will be reduced by the amount of Accelerated Death Benefits paid, if any, under this Rider.

## RIDER COST

The current monthly premium and the maximum monthly premium amount for this rider are shown on the Certificate Schedule. We may use premium rates lower than the maximum rate but will not use rates higher than the maximum rate.

## RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Owner in writing of a different date.

## TERMINATION

This Rider will terminate on the earliest of the following dates or events:

1. The date the contract terminates;
2. The date the contract Lapses, subject to the Grace Period;
3. The date the Owner requests termination;
4. The date the Insured dies;
5. The date on which cumulative monthly Accelerated Death Benefit payments equal 100% of the Death Benefit Amount, subject to any rights under an optional Extension of Benefits Rider;
6. The date on which we pay a one-time lump sum Accelerated Death Benefit payment in lieu of any monthly Accelerated Death Benefit

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Blake Bostwick
President

Jay Orlandi
Secretary

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

## DISCLOSURE UPON THE PURCHASE OF THE ACCELERATED DEATH BENEFIT FOR CHRONIC CONDITION RIDER

**SPECIAL NOTICE**

Benefits received under this Rider may be taxable as income. Whether any tax liability is incurred when benefits are paid under this Rider could depend on whether your employer has paid the premium, and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult an independent tax advisor to evaluate any tax impact of this benefit.

Receipt of an Accelerated Death Benefit may affect eligibility for Medicaid or other government benefits or entitlements. Unless you exercise this option, the mere fact that this Rider is part of your contract will not, in and of itself, affect the eligibility for these government programs. However, exercising this option before you apply for these programs, or while you are receiving government benefits, may affect your continued eligibility. Contact the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office for more information.

This disclosure is designed to provide you with a summary of the Rider coverage. The Rider form and the life contract set forth in detail the terms, conditions, limitations and exclusions of your coverage. Therefore, if you purchase this coverage, it is important that you **READ YOUR LIFE INSURANCE CONTRACT AND ALL RIDERS CAREFULLY.**

If you have any questions or concerns about any benefits or provision of your Accelerated Death Benefit For Chronic Condition Rider, please contact your agent or us directly at 1-888-763-7474.

1. **Benefits -** After our receipt of written proof that an Insured has met the Eligibility for Benefits provision, the Owner may choose to receive a portion of the Death Benefit while the Insured is still alive and while the Rider is in force, until the entire Death Benefit has been paid out.

   **Eligibility for Benefits -** We will pay an Accelerated Death Benefit under this Rider after we receive written proof that the Insured has met *all* of the following conditions.
   1. A Physician has certified that the Insured has a Chronic Condition;
   2. The Insured has satisfied the Elimination Period; and
   3. The contract to which this Rider is attached is in force.

   **Accelerated Death Benefit Options –** You may choose one of the following options for submitting a claim for an Accelerated Death Benefit under this Rider:

   **Option 1 – Monthly Accelerated Death Benefit –** You may request a monthly Accelerated Death Benefit equal to the applicable percentage of the Death Benefit Amount shown on the Certificate Schedule. This benefit is payable for each month the Insured satisfies the Eligibility for Benefits provision while this Rider is in force. After submitting satisfactory proof of loss, in order to continue receiving the monthly benefit you must provide, every 90 days, a written certification by a Physician that the Insured continues to have a Chronic Condition.

   **Option 2 - One-Time Lump Sum Accelerated Death Benefit –** In lieu of the monthly Accelerated Death Benefit, you may request a one-time lump sum Accelerated Death Benefit payment equal to the applicable percentage shown on the Certificate Schedule of the Death Benefit Amount. Upon payment of this lump sum benefit, your rights under this Rider will end and this Rider will terminate.

   **Concurrent and/or Subsequent Chronic Conditions**
   If the Insured suffers from more than one Chronic Condition, we will pay an Accelerated Death Benefit under this Rider for only one of the conditions. Under no circumstances will we pay an Accelerated Death Benefit for any subsequent Chronic Condition under this rider.

   A separate claim must be submitted for consideration under any other Accelerated Death Benefit Rider attached to the contract.

Payment of an Accelerated Death Benefit under this Rider will not reduce any Accidental Death benefit available under the contract.

2. **Definitions -** These are some of the important definitions that will help you understand the Benefits provision.

   **Activities of Daily Living –** For the purposes of this Rider, each of the following activities is considered an Activity of Daily Living:
   **Bathing** - The Insured's ability to wash himself or herself by sponge bath; or in a tub or shower, including the task of getting into and out of the tub or shower.
   **Continence –** The Insured's ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
   **Dressing** - The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
   **Eating** - The Insured's ability to feed himself or herself by getting food into his or her body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
   **Toileting –** The Insured's ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.
   **Transferring** - The Insured's ability to move into or out of a bed, chair or wheelchair.

   **Chronic Condition –**
   a. The inability, expected to be permanent, to perform, without Substantial Human Assistance, at least two Activities of Daily Living for a period of at least 90 days; **or**
   b. Severe Cognitive Impairment that is expected to be permanent and that requires Substantial Supervision to protect the Insured from threats to his or her health and safety.

   **Severe Cognitive Impairment –** A severe loss or deterioration in intellectual capacity that is comparable to and includes advanced Alzheimer's disease and is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in the Insured's:
   1. short-term or long-term memory;
   2. orientation as to person, place and time;
   3. deductive or abstract reasoning; or
   4. judgment as it relates to safety awareness.

   **Elimination Period –** The number of consecutive days during which the Insured must meet the conditions listed under the Benefits provision and during which no benefits are payable under this Rider. The Elimination Period starts on the day the Insured's Chronic Condition begins, as stated in the Physician's certification. The Elimination Period for this Rider is shown on the Contract Data Pages. The Elimination Period needs to be satisfied only once during the Insured's lifetime.

3. **Premiums –** The current monthly premium and the maximum monthly premium amount for this rider are shown on the Certificate Schedule. We may use premium rates lower than the maximum rate but will not use rates higher than the maximum rate.

4. **Waiver of Monthly Premium –** For each month or partial month that benefits are paid under this Rider, we will waive the monthly premium for the contract. If you elect the one-time lump sum Accelerated Death Benefit option, this waiver provision will not apply.

5. **Exclusions** - We will **not** pay Rider benefits if the Insured meets the requirements of the Eligibility for Benefits provision as a result of:
   a. An intentionally self-inflicted injury, or attempted suicide;
   b. War or any act of war, declared or undeclared, or service in the armed forces of any country;
   c. The Insured's alcohol, drug or other chemical dependence, except if the drug dependency is for a drug prescribed by a Physician in the course of treatment for an injury or sickness; or
   d. The Insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the Insured's involvement in an illegal activity.

6. **Impact on Death Benefit –** We will deduct any amounts paid under this Rider from the Insured's Death Benefit and send the Owner a monthly report showing the effect of each payment on the Insured's Death Benefit. The Insured's beneficiary will receive any remaining Death Benefit after the Insured dies, provided the contract has not stopped. However, if the entire Death Benefit has been accelerated prior to the Insured's death, the contract will terminate and there will be no Death Benefit payable upon the Insured's death.

   Once Rider benefit payments begin, you cannot change the Death Benefit of the contract or add any Riders, and we will not accept any premium payments.

   **Illustrative Example** of the effect of exercising the Accelerated Death Benefit option based on monthly benefit acceleration of 4% of the Death Benefit:

| | Death Benefit | Accelerated Death Benefit Amount | Accumulation Value | Surrender Charge |
|---|---|---|---|---|
| Before payment of Accelerated Benefit | $50,000 | | $5,000 | $500 |
| After one month's payment of Accelerated Death Benefit: | $48,000 | $2,000 | $4,800 | $480 |

**Acknowledgment**

I acknowledge that I have read this disclosure and understand that if I exercise the Accelerated Death Benefit option, any Beneficiary I designate may receive either a reduced Death Benefit or no Death Benefit at all. If the entire Death Benefit is paid out as an Accelerated Death Benefit prior to the Insured's death, the Beneficiary I designate will receive no Death Benefit.

_____

Date Owner's Signature

Please return a signed copy to Our Administrative Office address shown at the top of this form

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

# ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

(The Death Benefit under the contract will be reduced if a Rider benefit is paid)

**SPECIAL NOTICE**

This Rider is intended to provide a qualified accelerated death benefit that is excluded from gross income for federal income tax purposes. Whether any tax liability may be incurred when benefits are paid under this Rider could depend on whether you are also the Insured and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult an independent tax advisor to evaluate any tax impact of this benefit.

Receipt of acceleration of life insurance benefits may affect your, your spouse's or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect you, your spouse's and your family's eligibility for public assistance.

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the contract will prevail. This Rider has no cash value.

## DEFINITIONS

**Immediate Family Member** - The Owner or the Insured (if they are not one and the same) and his or her Spouse or Other Adult Dependent as well as his or her Child, brother, sister, mother or father, or the spouse of one of these individuals.

**Physician** - A duly licensed or certified practitioner of medicine, other than an Immediate Family Member, who is legally licensed to diagnose and treat any sickness or injury within the scope of his or her license.

**Terminal Illness –** Is an illness that, in the best medical judgment of a Physician, will result in death within 12 months.

## BENEFIT

We will pay an accelerated death benefit under this Rider if the Insured is diagnosed with a Terminal Illness for the *first* time, *on or after* the Rider Effective Date. The maximum amount that you can accelerate is shown on the Certificate Schedule.

## EFFECT ON INSURED'S DEATH BENEFIT

If you exercise this option, we will deduct the amount we accelerate from the Insured's Death Benefit. The Insured's Beneficiary will receive the remaining amount of the Death Benefit after the Insured dies, provided the contract has not stopped. After payment of an accelerated death benefit, we will send you a benefit report that will show the proportionate reduction in the premiums under the contract, if any.

## LIMITATIONS

We will not pay an accelerated death benefit under this Rider for any Terminal Illness that is diagnosed for the *first* time, prior to the Rider Effective Date.

We will pay an accelerated death benefit only once. If you ask for less than the maximum amount available when you submit a claim, you cannot ask us at a later time to give you the difference between what you did ask for and what you could have asked for.

## CLAIMS

The following Claims Procedures apply to this Rider.

**Notice of Claim -** We must be notified of a claim for benefits under this Rider, in writing, within 30 days of the initial date that the Insured is first diagnosed with a Terminal Illness. The written notice must be sent to our agent or to us. The notice must include sufficient information to identify the claimant. If notice cannot reasonably be given within 30 days of a loss, notice must be sent as soon as reasonably possible.

**Claim Forms -** After we receive notice of claim, we will send you the claim forms within 15 days. If the forms have not been received within 15 days, you may send us written proof of loss describing the nature and extent of the claim. The written proof of loss must be sent to us within the time limit stated in the following paragraph.

**Written Proof of Loss -** We will pay benefits under this Rider after we receive written proof of loss. We must receive such proof within 90 days after the Insured is diagnosed with a Terminal Illness. If it is not reasonably possible to provide this information within such time, written proof of loss must be submitted as soon as reasonably possible but no later than one year from the time specified.

Written proof of loss means a written statement signed by a Physician certifying that the Insured has been diagnosed with a Terminal Illness for the ***first*** time. Such certification must also show the date of the original diagnosis and the specific condition diagnosed.

**Physical Examination -** At our expense, we reserve the right to have a Physician of our choosing examine the Insured while a claim is pending to determine eligibility for benefits. In the event that the Physician we choose provides a different diagnosis of the condition, we reserve the right to rely on the certification from the Physician of our choosing for claim purposes.

**Time of Payment of Claims -** All benefits described in this Rider will be paid as soon as we have received written proof of loss satisfactory to us.

**Payment of Claims -** We will pay the accelerated death benefit under this Rider to the Owner, unless a different payee is designated.

**Legal Actions -** No legal action may be brought to recover under the contract within 60 days after written proof of loss has been provided to us as required nor more than 3 years from the time written proof of loss is required to be furnished.

## GENERAL RIDER PROVISIONS

**Consent for Benefit Payment:** If there is an assignment of the contract on record or an irrevocable Beneficiary on record, we must obtain the consent of such assignee or irrevocable Beneficiary before any Rider benefit is paid.

**Contestability -** This Rider will be contestable on the same basis as the contract, during the lifetime of the Insured, for two years from the Rider Effective Date.

**Suicide:** If the Insured dies by suicide, while sane or insane, within two years from the Rider Effective Date, any premiums refunded under the Suicide Exclusion provision of the contract will be reduced by the amount of accelerated benefits paid, if any, under this Rider.

## PREMIUM

There is no cost for this Rider, unless you decide to exercise this option. If you decide to exercise this option, you will have to pay:

1. An administrative fee of $100; and
2. 12 months interest, in advance, on the amount that we accelerate. The interest rate will not exceed the greater of:
   a. The current yield on ninety (90) day Treasury bills; or
   b. The current maximum statutory adjustable policy loan interest rate.

## EFFECTIVE DATE

The Rider Effective Date is the same date as the contract Effective Date unless we inform the Owner in writing of a different date.

## TERMINATION

This Rider stops at the earlier of:
1. The date the contract terminates;
2. The date the Insured dies; or
3. The date we have paid the accelerated death benefit for the Insured.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary President

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

## DISCLOSURE UPON THE PURCHASE OF THE ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

### SPECIAL NOTICE

This Rider is intended to provide a qualified Accelerated Death Benefit that is excluded from gross income for federal income tax purposes. Whether any tax liability may be incurred when benefits are paid under this Rider could depend on whether you are also the Insured and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult an independent tax advisor to evaluate any tax impact of this benefit.

Receipt of an accelerated Death Benefit MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") eligibility. Without exercising this option, the mere fact that the Accelerated Death Benefit for Terminal Illness Rider is part of your contract will not in and of itself affect the eligibility for these government programs. However, exercising this option before you apply for these programs, or while you are receiving government benefits, may affect your continued eligibility. Contact the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office for more information.

This disclosure is designed to provide you with a summary of the Rider coverage. The Rider form and the life contract set forth in detail the terms, conditions, limitations and exclusions of your coverage. Therefore, if you purchase this coverage, it is important that you **READ YOUR LIFE INSURANCE CONTRACT AND ALL RIDERS CAREFULLY.**

If you have any questions or concerns about any benefits or provision of your Accelerated Death Benefit For Terminal Illness Rider, please contact your agent or us directly at 1-888-763-7474.

1. **Description of Benefit -** Upon receipt of written proof acceptable to us that the Insured has 12 months or less to live because of a Terminal Illness, the Owner may choose to receive a portion of the Death Benefit while the Insured is still alive and while the Rider is in force.

   We will pay an accelerated death benefit under this Rider if the Insured is diagnosed with a Terminal Illness for the *first* time, *on or after* the Rider Effective Date. The Terminal Illness Accelerated Death Benefit amount will be equal to the lesser of: (1) up to 50% of the Death Benefit; or (2) $100,000.

   A **Terminal Illness** is an illness that in the best medical judgment of a Physician will result in death within 12 months.
2. **Premiums -** There is no cost for this Rider, unless the Owner exercises this option. If the Owner exercises this option, an administrative fee of $100 will be assessed. In addition, we will deduct 12 month's interest in advance on the amount. The interest rate will not exceed the greater of the current yield on ninety (90) day Treasury bills; or the current maximum statutory adjustable policy loan interest rate.
3. **Effect on Death Benefit -** If you exercise this option, we will deduct the amount we accelerate from the Insured's Death Benefit. The Insured's Beneficiary will receive the remaining amount of the Death Benefit after the Insured dies, provided the contract has not stopped. After payment of an accelerated death benefit, we will send you a benefit report that will show the proportionate reduction in the premiums under the contract, if any
4. **Illustrative Example** of the effect of exercising the Accelerated Death Benefit option based on acceleration of 50% of the Death Benefit:

| | Death Benefit | Accelerated Death Benefit Amount |
|---|---|---|
| Before payment of Accelerated Benefit | $50,000 | $0 |
| After payment of Accelerated Benefit | $25,000 | $25,000* |

* The Accelerated Death Benefit amount elected will be reduced by an administrative fee of $100 and interest of 12 months.

5. **Limitations -** We will not pay an accelerated death benefit under this Rider for any Terminal Illness that is diagnosed for the ***first*** time, prior to the Rider Effective Date.

   We will pay an accelerated death benefit only once. If you ask for less than the maximum amount available when you submit a claim, you cannot ask us at a later time to give you the difference between what you did ask for and what you could have asked for.

**ACKNOWLEDGMENT**

I acknowledge that I have read this disclosure and understand that if I exercise the Accelerated Death Benefit option, any Beneficiary I designate may receive a reduced Death Benefit.

| | |
|---|---|
| Date | Owner's Signature |

Please return a signed copy to our Administrative Office address shown at the top of this form

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: PO Box 869094 Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

## WAIVER OF PREMIUM DUE TO LAYOFF OR STRIKE RIDER

This Rider is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail. This Rider has no cash value.

### DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

**Layoff** - The Owner has been employed on a full-time basis at the time of the Layoff and is involuntarily terminated by his or her employer due to one of the following reasons.

1. A reduction in work force as the result of economic conditions;
2. The employer's decrease in production; or
3. The employer's reorganization causing the discontinuation of the Owner's job or resulting in a change of aptitude or skill requirements of his or her job.

**Strike –** A work stoppage at the Owner's place of employment that is supported and/or sponsored by the state or national union headquarters.

### BENEFITS

We will waive the monthly premiums on the contract if the Owner is placed on Layoff status or is on Strike, provided that the first premium on the contract to which this rider is attached has be paid. Monthly premiums will begin being waived the first day of the month following the date of Layoff or Strike.

### LIMITATIONS AND EXCLUSIONS

We will waive premiums for up to 3 Layoffs or Strikes in any one 12-month period.
We will wave premiums for up to 6 months in any one 12-month period.
A 12-month period will be measured from the date the first premium is waived.

If the Portability Option provision of the contract has been exercised, if any, the Owner will need to provide proof of being employed (other than self-employment) for the 6 months prior to the Layoff or Strike.

This Rider is not available for self-employed individuals.

### PREMIUM

The premium for this Rider is shown on the Certificate Schedule.

### EFFECTIVE DATE

The Rider Effective Date is the same date as the contract Effective Date, unless we inform the Owner in writing of a different date.

### TERMINATION

This Rider will terminate on the earliest of:

1. The date the contract terminates;
2. The date the Rider or contract Lapses for failure to pay premium, subject to the Grace Period of the contract;
3. The date the Owner requests termination;
4. The date the Owner dies;
5. The Certificate Anniversary Date on or following the Insured's 65th birthday; or
6. The date the Owner assigns the contract to another individual.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

## COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS

Agents who sell and service our products are paid a commission. It varies by the type of insurance policy sold and the state where the policy was sold, and is based on a percentage of the premium received in the first year, and at policy renewal. Agents may receive advances or loans against anticipated commissions for cases sold or to be sold. These advances may or may not require the payment of interest, depending upon the agent's total business and historical experience with TEB.

Agents may receive other compensation from TEB in the form of cash or non-cash awards or prizes, based upon a variety of factors that may include the level of premium written or earned, persistency and growth of premium, or other performance measures. Agents who manage, supervise or recruit other agents or wholesale our products and services to other agents, may receive commission overrides on business that results from their efforts.

Some of our agents may receive additional payments for providing services in connection with the administration of our products. Fees for such services may be calculated on a per policy or per certificate basis or upon the premium volume associated with a specific case. TEB may additionally reimburse these agents/administrators for certain expenses, such as the cost of mailings.

Agents may occasionally obtain exclusive rights to market TEB products or services to agents, employers, employees or members of associations or unions. Certain groups or associations may also agree to endorse TEB's products to their members. TEB may pay a fee for these exclusive marketing rights or endorsements. See your proposed plan documents or policy certificate package for more information on any such arrangements.

For up to date information regarding our compensation practices, please consult our website at: www.transamericaemployeebenefits.com.

# Forest River, Inc.

## Your Accident Plan

Policy No. 984567 012

Underwritten by Unum Insurance Company

10/24/2025

**Unum Insurance Company**
2211 Congress Street
Portland, ME 04122
(877) 225-2712
services.unum.com

## Group Accident Insurance Certificate of Coverage

We welcome you as a customer and are committed to providing quality service. This is your Accident Certificate of Coverage. Accident coverage can ease the potential financial impact of unforeseen accidents by providing benefits. This certificate describes your Accident benefits in detail.

**Policyholder:** Forest River, Inc.

**Policy Number:** 984567 012

**Policy Effective Date:** November 1, 2025

**Policy Anniversary:** January 1

**Governing Jurisdiction:** Indiana

This certificate is issued to you under the Policy which is a contract between us and the Policyholder. If the terms and provisions of this certificate are different from the Policy, the Policy will govern. A copy of the Policy may be made available to you upon request. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

All references to provisions, sections, and defined terms found within this certificate have been capitalized. If you have any questions about the terms and provisions of this certificate, please contact your Employer or us at (877) 225-2712 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

**This Certificate of Coverage provides limited benefits under the non-participating Policy. The limited benefits provided under this Certificate of Coverage are a supplement to major medical coverage and are not a substitute for major medical coverage or other minimal essential coverage as required by federal law.**

**This certificate contains certain proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an Insured from receiving benefits under this certificate. Please read your certificate carefully and keep it in a safe place.**

Your certificate includes notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the Indiana Department of Insurance at (800) 622-4461.

## Consumer Complaint Notice

**If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.**

## Table of Contents


**Accident Highlights** ..... **4**

Eligible Group(s) ..... 4

Paying for Coverage ..... 4

Schedule of Benefits ..... 4

**Accident Details** ..... **8**

Injury Benefits ..... 8

Treatment and Other Benefits ..... 11

Surgery Benefits ..... 16

Hospital Benefits ..... 19

Recovery Care Benefits ..... 20

Accidental Death and Dismemberment Benefits ..... 21

**Accident Details | Exclusions and Limitations** ..... **25**

**Accident Details | Other Features** ..... **26**

**Start of Coverage** ..... **27**

**End of Coverage** ..... **29**

**Claim Provisions** ..... **31**

**General Provisions** ..... **35**

**Glossary** ..... **37**

**State Requirements** ..... **43**

Accident Insurance provides financial protection for an Insured by paying benefits if an Insured is involved in a Covered Accident that results in a Covered Loss payable under this certificate.

This section includes highlights of an Insured's coverage. Please refer to the **Accident Details** for further information on the benefits available.

**Eligible Group(s)**

All Full Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

**Paying for Coverage**

*For you*
*Contributory Coverage*
You must make premium contributions for your coverage.

*For your Spouse*
*Contributory Coverage*
You must make premium contributions for your Spouse's coverage.

*For your Children*
*Contributory Coverage*
You must make premium contributions for your Children's coverage.

## Schedule of Benefits

The following Schedule of Benefits is available to you during an Enrollment Period. You will have the opportunity to apply for coverage for you, your Spouse, and Children.

The benefits an Insured may receive for a Payable Claim are listed in the Schedule of Benefits, subject to all other terms and provisions of this certificate. Amounts are the same for all Insureds, unless noted otherwise. Multiple benefits may be payable for a single Covered Accident.

**Injury Benefits**

| | |
|---|---|
| *Burns* | |
| *2nd Degree Burns* | |
| At least 5%, but less than 20% of skin surface | $1,000 |
| 20% or greater of skin surface | $2,000 |
| *3rd Degree Burns* | |
| Less than 5% of skin surface | $4,000 |
| At least 5%, but less than 20% of skin surface | $10,000 |
| 20% or greater of skin surface | $20,000 |
| Concussion | $500 |
| *Connective Tissue Damage* | |
| One Connective Tissue | $90 |
| Two or more Connective Tissues | $150 |
| *Dislocations* | |
| Ankle bone or bones of the foot (other than toes) | $3,000 |
| Collarbone (acromioclavicular and separation) | $600 |
| Collarbone (sternoclavicular) | $2,000 |
| Elbow joint | $2,000 |
| Finger or Toe (Digit) | $500 |
| Hand (other than Fingers) | $2,000 |
| Hip joint | $6,000 |
| Knee joint (other than patella) | $4,000 |
| Kneecap (patella) | $3,000 |
| Lower Jaw | $2,000 |
| Shoulder | $2,500 |
| Wrist joint | $2,500 |
| Incomplete Dislocation | |

| | |
|---|---|
| *Payable as a % of the applicable Dislocations benefit* | 25% |
| Eye Injury | $200 |
| *Fractures* | |
| Ankle (lower tibia or fibula) | $3,000 |
| Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla) | $2,000 |
| Collarbone (clavicle, sternum) or Shoulder Blade (scapula) | $2,500 |
| Finger or Toe (Digit) | $500 |
| Foot or Heel (other than Toes) | $3,000 |
| Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers) | $3,000 |
| Hip or Thigh (femur) | $6,000 |
| Kneecap (patella) | $3,000 |
| Leg (mid to upper tibia or fibula) | $3,500 |
| Lower Jaw, Mandible (other than alveolar process) | $2,500 |
| Pelvis | $5,000 |
| Rib | $800 |
| Skull (except bones of Face or Nose), Depressed | $8,000 |
| Skull (except bones of Face or Nose), Non-depressed | $4,000 |
| Tailbone (coccyx), Sacrum | $800 |
| Upper Arm between Elbow and Shoulder (humerus) | $3,500 |
| Upper Jaw, Maxilla (other than alveolar process) | $2,000 |
| Vertebrae, body of (other than Vertebral Processes) | $5,000 |
| Vertebral Processes | $800 |
| Chip Fracture<br>*Payable as a % of the applicable Fractures benefit* | 25% |
| Injury due to Felony Assault or Sexual Assault | $250 |
| Internal Injuries | $200 |
| Knee Cartilage (Meniscus) Injury | $250 |
| *Lacerations* | |
| No Repair | $85 |
| *Repair* | |
| Less than 2 inches | $250 |
| At least 2 inches but less than 6 inches | $500 |
| 6 inches or greater | $1,000 |
| *Loss of a Digit* | |
| One Digit (other than a Thumb or Big Toe) | $1,250 |
| One Digit (a Thumb or Big Toe) | $1,875 |
| Two or more Digits | $2,500 |
| Organized Sports | 50% |
| *Ruptured or Herniated Disc* | |
| One Disc | $210 |
| Two or more Discs | $350 |

**Treatment and Other Benefits**

| | |
|---|---|
| *Ambulance* | |
| Air | $1,500 |
| Ground | $500 |
| *Durable Medical Equipment* | |
| Tier 1 | $75 |
| Tier 2 | $150 |
| Tier 3 | $300 |
| *Emergency Dental Repair* | |
| Dental Crown | $600 |
| Dental Extraction | $200 |
| Filling or Chip Repair | $150 |

| | |
|---|---|
| Emergency Department | $350 |
| Family Care | $50 |
| Injections to Prevent or Limit Infection | $50 |
| Lodging | $250 |
| *Medical Imaging* | |
| Tier 1: X-rays or Ultrasound | $250 |
| Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI | $500 |
| Organized Sports | 50% |
| Pain Management Injections | $200 |
| Pet Boarding | $30 |
| *Prosthetic Device or Artificial Limb* | |
| One Device or Limb | $1,250 |
| Two or more Devices or Limbs | $2,500 |
| *Skin Grafts* | |
| *Due to Burns* | |
| *Payable as a % of the applicable Burn benefit* | 50% |
| *Not due to Burns* | |
| Less than 20% of skin surface | $500 |
| 20% or greater of skin surface | $1,000 |
| Transfusions | $600 |
| Transportation | $500 |
| Treatment in a Physician's Office or Urgent Care Facility | $500 |

**Surgery Benefits**

| | |
|---|---|
| *Anesthesia* | |
| Epidural or Regional Anesthesia | $140 |
| General Anesthesia | $350 |
| *Connective Tissue Surgery* | |
| Exploratory without Repair | $150 |
| Repair for One Connective Tissue | $1,200 |
| Repair for Two or more Connective Tissues | $1,800 |
| Dislocations - Surgical Repair<br>*Payable as a % of the applicable Injury benefit* | 100% |
| Eye Surgery | $500 |
| Fractures - Surgical Repair<br>*Payable as a % of the applicable Injury benefit* | 100% |
| *General Surgery* | |
| Abdominal, Thoracic, or Cranial | $2,500 |
| Exploratory | $250 |
| Hernia Surgery | $250 |
| *Knee Cartilage (Meniscus) Surgery* | |
| Exploratory without Repair | $300 |
| Knee Cartilage (Meniscus) with Repair | $1,500 |
| Outpatient Surgical Facility | $500 |
| *Ruptured or Herniated Disc Surgery* | |
| Exploratory without Repair | $175 |
| Repair for One Disc | $1,000 |
| Repair for Two or more Discs | $1,500 |

**Hospital Benefits**

| | |
|---|---|
| Admission | $2,000 |
| Daily Stay | $500 |
| Short Stay | $200 |

**Recovery Care Benefits**

| | |
|---|---|
| At-Home Care | $150 |
| Behavioral Health Therapy | $100 |
| Physician Follow-Up Visits | $250 |

| | |
|---|---|
| Prescription Drug | $50 |
| Rehabilitation or Subacute Rehabilitation Unit | $200 |
| Therapy Services | $150 |

**Accidental Death and Dismemberment Benefits**

| *Accidental Death* | |
|---|---|
| **Employee** | $100,000 |
| **Spouse** | $50,000 |
| **Children** | $25,000 |
| *Accidental Death - Common Carrier* | |
| **Employee** | $100,000 |
| **Spouse** | $50,000 |
| **Children** | $25,000 |
| *Accidental Dismemberment* | |
| Both Feet | $100,000 |
| Both Hands | $100,000 |
| One Foot | $50,000 |
| One Hand | $50,000 |
| Thumb and Index Finger of the same Hand | $25,000 |
| Coma | $20,000 |
| Home Alterations and Automobile Modifications | $2,000 |
| *Loss of Use* | |
| Hearing (one ear) | $25,000 |
| Hearing (both ears) | $50,000 |
| Sight of one Eye | $50,000 |
| Sight of both Eyes | $100,000 |
| Speech | $50,000 |
| *Paralysis* | |
| Uniplegia | $25,000 |
| Hemiplegia | $50,000 |
| Paraplegia | $50,000 |
| Triplegia | $75,000 |
| Quadriplegia | $100,000 |

The information in this section provides details about the benefits that may be payable to you, any applicable Exclusions, and Other Features included in your coverage.

Benefits will only be payable for Covered Accidents that occur on or after the Insured's Coverage Effective Date. Benefits will not be paid for any Injury, treatment or care due to causes other than Covered Accidents.

**Coverage Type**

This certificate provides coverage for accidents that happen only when an Insured is not working.

If an accident was caused by or aggravated by any employment for pay or profit, it is considered to have happened while working.

## Injury Benefits

**Burns**

*Benefit Description*

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a 2nd or 3rd degree Burn in a Covered Accident.

Burns are damage to the skin or deeper tissues caused by sun, hot liquids, fire, electricity, or chemicals. Burns are characterized by severe skin damage that causes the affected skin cells to die.

A Physician must diagnose the Burn within 90 days of the Covered Accident.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

If an Insured sustains more than one type of Burn in a single Covered Accident, we will pay for the Burn with the highest benefit amount.

**Concussion**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured sustains a Concussion in a Covered Accident.

A Concussion is a mild traumatic brain injury that alters the way the brain functions. Effects are usually temporary but can include headaches and problems with concentration, memory, balance, and coordination.

A Physician must diagnose the Concussion within 14 days of the Covered Accident.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

**Connective Tissue Damage**

*Benefit Description*

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains one or more completely torn, ruptured, or severed Connective Tissues in a Covered Accident.

A Physician must diagnose the Connective Tissue Damage within 90 days of the Covered Accident.

For purposes of this benefit, the following are considered Connective Tissues:
- tendons;
- ligaments;
- rotator cuffs; and
- muscles.

For purposes of this benefit, the following do not meet the Benefit Description of Connective Tissue Damage:
- sprains; and
- pulled muscles.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Dislocations**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a dislocated joint in a Covered Accident.

If an Insured has an Incomplete Dislocation, we will pay the percentage amount shown in the Schedule of Benefits for the joint involved.

A Dislocation is an Injury to a joint where the ends of the bones are forced from their normal positions. An Incomplete Dislocation is a Dislocation in which the joint is not completely separated.

A Physician must set the dislocated joint within 90 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per joint per Covered Accident.

If an Insured sustains multiple dislocated joints in a single Covered Accident, we will pay for each joint, but will pay no more than two times the amount for the joint involved with the highest benefit amount.

If the dislocation requires a Surgical Procedure, an Insured may also be eligible for the Dislocations - Surgical Repair benefit.

We will pay additional Dislocations benefits for a dislocation of the same joint if the dislocation is sustained in a different or unrelated Covered Accident and is more than 180 days after the prior Covered Accident.

**Eye Injury**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured sustains an Eye Injury in a Covered Accident.

The Eye Injury must require the removal of a foreign object with or without anesthesia.

A Physician must remove the object within 90 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Fractures**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a fractured bone in a Covered Accident.

If an Insured has a Chip Fracture, we will pay the percentage amount shown in the Schedule of Benefits for the bone involved.

A fracture is a break of a bone. A Chip Fracture is a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

A Physician must confirm the bone fracture within 90 days of the Covered Accident by X-ray or other medical imaging study.

For purposes of this benefit, a bone injury diagnosed as a stress fracture does not meet the Benefit Description of Fractures.

*Benefit Duration*
This benefit is payable once per Insured per bone per Covered Accident.

If an Insured sustains multiple Fractures of the same bone in a single Covered Accident, we will only pay one Fractures benefit for that bone.

If an Insured sustains Fractures of multiple bones in a single Covered Accident, we will pay for each bone, but will pay no more than two times the amount for the bone involved with the highest benefit amount.

If the fracture requires a Surgical Procedure, an Insured may also be eligible for the Fractures - Surgical Repair benefit.

We will pay additional Fractures benefits for a fracture of the same bone if the fracture is sustained in a different or unrelated Covered Accident and is more than 180 days after the prior Covered Accident.

**Injury due to Felony Assault or Sexual Assault**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured receives a qualifying treatment due to an Injury sustained as the victim of a Felonious Act of Violence or Sexual Assault in a Covered Accident.

The Injury due to Felony Assault or Sexual Assault must include a police report.

For purposes of this benefit, qualifying treatment must:
- be due to Injuries received as a result of a Felonious Act of Violence or Sexual Assault;
- be payable under this certificate's Schedule of Benefits for Emergency Department or Treatment in a Physician's Office or Urgent Care Facility; and
- occur within three days after the assault.

*Benefit Duration*

This benefit is payable a maximum of once per Insured per Calendar year.

**Internal Injuries**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured sustains an Internal Injury in a Covered Accident.

A Physician must diagnose the Internal Injury within 90 days of the Covered Accident.

For purposes of this benefit, Internal Injuries include:
- a collapsed or punctured lung;
- a ruptured or torn spleen, kidney, or liver; or
- a ruptured eardrum.

For purposes of this benefit, the following do not meet the Benefit Description of Internal Injuries:
- bruised organs or muscles;
- internal bleeding;
- swollen glands or organs;
- injuries to teeth, bones, joints or other connective tissues; and
- injuries for which another Injury Benefit is payable.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

**Knee Cartilage (Meniscus) Injury**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured sustains a partially torn or fully torn Knee Cartilage in a Covered Accident.

Knee Cartilage is the area of tissue which acts like a shock absorber in the joint called the meniscus. The meniscus may be partially torn or fully torn by a forceful knee movement while weight bearing on the same leg.

A Physician must confirm the Knee Cartilage (Meniscus) Injury within 90 days of the Covered Accident by an MRI, other medical imaging study, or Surgical Procedure.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Lacerations**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a Laceration in a Covered Accident.

A Laceration is an open wound or cut on the outside of the body.

A Physician must treat the Laceration within three days of the Covered Accident.

For purposes of this benefit, the following are considered repair techniques used by a Physician:
- stitches;
- staples; and
- tissue adhesive.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

If an Insured sustains multiple Lacerations in a single Covered Accident, the amount payable will be based on the total length of all Lacerations sustained requiring repair.

**Loss of a Digit**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains permanent and total loss of one or more fingers, thumbs, or toes in a Covered Accident.

A Physician must treat the Loss of a Digit within 90 days of the Covered Accident.

For purposes of this benefit, the following losses meet the Benefit Description of Loss of a Digit:
- for fingers and thumbs, the digit must be cut off below the joint closest to the fingertip; and
- for toes, the digit must be cut off at the joint where it is attached to the foot.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Ruptured or Herniated Disc**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a Ruptured or Herniated Disc in a Covered Accident.

A Ruptured or Herniated Disc, also known as a slipped disc, occurs when one of the intervertebral discs in the spine develops a crack in its outer wall, allowing the inner core to leak out in to the spinal canal, causing pain or numbness.

A Physician must diagnose the Ruptured or Herniated Disc within 90 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

## Treatment and Other Benefits

**Ambulance**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if a licensed professional ambulance company transports an Insured by air or ground to or from a Hospital or between medical facilities where treatment is received due to Injuries sustained in a Covered Accident.

If an Insured is treated by Ambulance staff, but is not transported for a Covered

Accident, we will pay the corresponding amount shown for Ambulance - Ground.

The Ambulance transportation must be within 180 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident for each mode of Ambulance transportation.

**Durable Medical Equipment**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured is prescribed Durable Medical Equipment by a Physician or Therapist as an aid in treatment, recovery, or mobility due to Injuries sustained in a Covered Accident.

The Durable Medical Equipment must be prescribed to the Insured within 90 days of the Covered Accident.

**Durable Medical Equipment**

| | | |
|---|---|---|
| **Tier 1** | - Arm Sling<br>- Cane<br>- Medical Ring Cushion | - Neck Brace<br>- Wrist or Ankle Splint |
| **Tier 2** | - Bedside Commode<br>- Cold Therapy System (Cryotherapy)<br>- Crutches | - Leg Brace<br>- Shower Chair<br>- Walker or Walking Boot that extends above the ankle |
| **Tier 3** | - Back Brace<br>- Body Jacket<br>- Continuous Passive Movement (CPM)<br>- Electric Scooter | - Halo<br>- Hospital Bed<br>- Knee Scooter<br>- Stair Lift Chair<br>- Wheelchair |

We will use a current relative value scale to determine the appropriate Tier amount for any medical equipment not listed above.

For purposes of this benefit, the Durable Medical Equipment must:
- be designed for and able to withstand repeated use by more than one person;
- customarily serve a medical purpose; and
- be generally not useful in the absence of an Injury or Sickness.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

If an Insured is prescribed multiple pieces of Durable Medical Equipment as a result of a single Covered Accident, we will pay for each piece of Durable Medical Equipment, but will pay no more than three times the amount for the piece of Durable Medical Equipment with the highest Tier amount per Calendar year.

**Emergency Dental Repair**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured has an Emergency Dental Repair for a partially broken or broken tooth sustained in a Covered Accident.

The partially broken or broken tooth must require repair by a Dental Crown, or Dental Extraction, or Filling or Chip Repair.

The Emergency Dental Repair must be within 180 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

If an Insured has multiple Emergency Dental Repairs as a result of a single Covered Accident, we will pay for each Emergency Dental Repair, but will pay no more than three

times the amount for the Emergency Dental Repair with the highest benefit amount.

**Emergency Department**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured requires examination or treatment by a Physician in the Emergency Department due to Injuries sustained in a Covered Accident.

Emergency Department treatment must be within three days of the Covered Accident.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

We will pay additional Emergency Department benefits if:
- an Insured is treated in the Emergency Department due to Injuries sustained in a different or unrelated Covered Accident; or
- the Insured is treated in the Emergency Department more than 90 days after the date of the previous Emergency Department treatment.

**Family Care**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits for Family Care that takes place when an Insured has a Child attending a Child Care Center during an Insured's period of Confinement or when an Insured undergoes a Surgical Procedure due to Injuries sustained in a Covered Accident.

*Benefit Duration*

This benefit is payable a maximum of one benefit per day for all Insureds combined, up to a maximum of three days per Covered Accident, regardless of the number of Children, up to a maximum of four times per Insured per Calendar year.

**Injections to Prevent or Limit Infection**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured receives an injection after exposure to bacteria, viruses, or venom in a Covered Accident.

A Physician must administer the injection within 180 days of the Covered Accident.

For purposes of this benefit, the following are considered Injections to Prevent or Limit Infection:
- tetanus boosters;
- rabies shots;
- antivenom; and
- immune globulin.

For the purposes of this benefit, the following do not meet the Benefit Description of Injections to Prevent or Limit Infection:
- immunizations;
- tetanus boosters as part of routine medical care; and
- EpiPen injections intended to limit an allergic reaction.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

**Lodging**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits for each day of a hotel stay for a companion accompanying an Insured to a Surgical Procedure or during a period of Confinement due to Injuries sustained in a Covered Accident.

The Lodging must be within 180 days of the Covered Accident.

The Surgical Procedure or Confinement must be at a Hospital or other medical facility more than 50 miles from the companion's residence.

*Benefit Duration*

This benefit is payable up to a maximum of 30 days per Covered Accident.

**Medical Imaging**

*Benefit Description*

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Medical Imaging test ordered by a Physician due to Injuries sustained in a Covered Accident.

The Medical Imaging must be within 180 days of the Covered Accident.

For purposes of this benefit, X-rays are considered a single test, regardless of the number of images produced.

**Medical Imaging Tests**

| | | |
|---|---|---|
| **Tier 1** | - X-rays<br>- Ultrasound | |
| **Tier 2** | - Bone Scan<br>- Computed Axial Tomography (CAT)<br>- Computed Tomography Scan (CT)<br>- Electroencephalogram (EEG) | - Magnetic Resonance (MR)<br>- Magnetic Resonance Angiogram (MRA)<br>- Magnetic Resonance Imaging (MRI) |

*Benefit Duration*

This benefit is payable once per Insured per Tier of Medical Imaging Tests per Covered Accident.

**Organized Sports**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured has Injuries sustained in a Covered Accident while participating in an Organized Sport.

This benefit will be paid in addition to any benefit payable within the Injury Benefits or Treatment and Other Benefits categories.

*Benefit Duration*

This benefit is payable for each Covered Accident based on the payable amounts in the Schedule of Benefits.

**Pain Management Injections**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured receives an injection for the purposes of blocking pain in a particular region of the body due to Injuries sustained in a Covered Accident.

A Physician must administer the injection within 180 days of the Covered Accident.

For purposes of this benefit, the following are considered Pain Management Injections:
- cortisone shots;
- steroid shots; and
- epidural steroids.

For the purposes of this benefit, the following do not meet the Benefit Description of Pain Management Injections:
- oral prescriptions for pain relief;
- over the counter pain medications;
- topical pain management;
- general, regional, or local anesthesia; and
- pain management injections for chronic pain or causes other than a Covered Accident.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

**Pet Boarding**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits for Pet Boarding that takes place during an Insured's period of Confinement or when an Insured undergoes a Surgical Procedure due to Injuries sustained in a Covered Accident.

The Pet or Pets must be boarded overnight at a Pet Boarding Facility.

*Benefit Duration*

This benefit is payable a maximum of one benefit per day for all Insureds combined, up to a maximum of three days per Covered Accident.

**Prosthetic Device or Artificial Limb**

*Benefit Description*

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured receives a Prosthetic Device or Artificial Limb for a permanently missing hand, arm, foot, leg, or eye due to Injuries sustained in a Covered Accident.

The Prosthetic Device or Artificial Limb can be a newly required device or a replacement of an existing device, which was irreparably damaged in the Covered Accident.

The Prosthetic Device or Artificial Limb must be received within 365 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Prosthetic Device or Artificial Limb:

- hearing aids;
- dental aids (including false teeth);
- eyeglasses;
- cosmetic prostheses such as wigs; and
- artificial hips, knees, or other joint replacements.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

**Skin Grafts**

*Benefit Description*

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured receives a Skin Graft due to Injuries sustained in a Covered Accident.

A Skin Graft is the transplantation of a piece of skin to replace a lost portion of skin due to burns or other accidental traumatic loss of skin.

The Insured must receive the Skin Graft within 180 days of the Covered Accident.

*Benefit Duration*

This benefit is payable once per Insured per type of Skin Graft per Covered Accident.

**Transfusions**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured receives a Transfusion due to Injuries sustained in a Covered Accident.

A Transfusion is the receipt of blood, plasma, or platelets intravenously.

The Transfusion must be within 180 days of the Covered Accident.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

**Transportation**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits for any mode of Transportation, including a personal car, for an Insured and one companion if the Insured requires diagnosis, treatment, or a Surgical Procedure due to Injuries sustained in a Covered Accident.

The Transportation must be within 180 days of the Covered Accident.

The diagnosis, treatment, or Surgical Procedure must be at a Hospital or other medical facility more than 50 miles from the Insured's residence.

For purposes of this benefit, any mode of Ambulance transportation does not meet the Benefit Description of Transportation.

*Benefit Duration*
This benefit is payable up to a maximum of six one-way trips per Insured per Covered Accident. A trip must either start or end at the Insured's residence.

**Treatment in a Physician's Office or Urgent Care Facility**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured receives initial examination or treatment by a Physician due to Injuries sustained in a Covered Accident.

The Treatment in a Physician's Office or Urgent Care Facility must be within 14 days of the Covered Accident.

For purposes of this benefit, a routine physical or annual wellness exam and treatment that meets the Benefit Description of Therapy Services do not meet the Benefit Description of Treatment in a Physician's Office or Urgent Care Facility.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

## Surgery Benefits

**Anesthesia**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if general, epidural, or regional Anesthesia is administered to an Insured during a Surgical Procedure due to Injuries sustained in a Covered Accident.

General Anesthesia is the induction of a balanced state of unconsciousness, accompanied by the absence of pain sensation and the paralysis of skeletal muscle over the entire body. Epidural or regional Anesthesia is a form of regional anesthesia involving the injection of drugs through a catheter into the epidural space.

A Physician must administer the Anesthesia within 365 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Anesthesia:
- epidural anesthesia administered for Childbirth;
- peripheral nerve blocks; and
- local anesthesia.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Connective Tissue Surgery**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure to treat one or more torn, ruptured, or severed Connective Tissues sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

For purposes of this benefit, the following are considered Connective Tissues:
- tendons;
- ligaments;
- rotator cuffs; and

- muscles.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Dislocations - Surgical Repair**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits for a Surgical Procedure to repair a dislocated joint sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per joint per Covered Accident.

If an Insured sustains multiple dislocated joints in a single Covered Accident and they are repaired with a Surgical Procedure, we will pay the Dislocations - Surgical Repair benefit for each joint, but will pay no more than two times the amount for the joint involved with the highest benefit amount.

We will pay additional Dislocations - Surgical Repair benefits for a Surgical Procedure of the same joint if the dislocation is sustained in a different or unrelated Covered Accident and is more than 180 days after the prior Covered Accident.

**Eye Surgery**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure with anesthesia due to an Eye Injury sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Fractures - Surgical Repair**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits for a Surgical Procedure to repair a fractured bone sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per bone per Covered Accident.

If an Insured sustains multiple Fractures of the same bone in a single Covered Accident and they are repaired with a Surgical Procedure, we will only pay one Fractures - Surgical Repair benefits for that bone.

If an Insured sustains Fractures of multiple bones in a single Covered Accident and they are repaired with a Surgical Procedure, we will pay the Fractures - Surgical Repair benefit for each bone, but will pay no more than two times the amount for the bone involved with the highest benefit amount.

We will pay additional Fractures - Surgical Repair benefits for a Surgical Procedure of the same bone if the fracture is sustained in a different or unrelated Covered Accident and is more than 180 days after the prior Covered Accident.

**General Surgery**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure due to Injuries sustained in a Covered Accident.

If an exploratory abdominal, thoracic, or cranial Surgical Procedure is performed, we will pay the corresponding amount for General Surgery - Exploratory.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

For purposes of this benefit, the following are considered a General Surgery:
- abdominal surgery;
- thoracic surgery; and
- cranial surgery.

Benefits for General Surgery will not be paid for a Covered Accident for which any other Surgery benefits are paid.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Hernia Surgery**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure to repair a Hernia sustained in a Covered Accident.

A hernia occurs when an organ is displaced and protrudes through the wall of the cavity containing it.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Knee Cartilage (Meniscus) Surgery**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure to treat a Knee Cartilage (Meniscus) Injury sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Outpatient Surgical Facility**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure on an Outpatient Basis in a Hospital, Ambulatory Surgical Center, or other medical facility due to Injuries sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Outpatient Surgical Facility:
- Surgical Procedures performed in the Emergency Department; and
- Surgical Procedures performed while Confined in a Hospital or other medical facility.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Ruptured or Herniated Disc Surgery**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure to treat a Ruptured or Herniated Disc sustained in a Covered Accident.

A Ruptured or Herniated Disc, also known as a slipped disc, occurs when one of the intervertebral discs in the spine develops a crack in its outer wall, allowing the inner core to leak out into the spinal canal, causing pain or numbness.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

## Hospital Benefits

**Admission**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured is admitted and Confined to a Hospital due to Injuries sustained in a Covered Accident.

The Admission and Confinement must be within 180 days of the Covered Accident.

This benefit will be paid in addition to any Daily Stay Benefits.

For purposes of this benefit, the following Hospital services are not eligible:
- treatment in the Emergency Department;
- treatment on an Outpatient Basis; and
- any Confinement of less than 20 hours.

*Benefit Duration*
This benefit is payable up to a maximum of one day per Insured per Covered Accident.

**Daily Stay**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits for each day an Insured is Confined in a Hospital due to Injuries sustained in a Covered Accident.

The Confinement must begin within 180 days of the Covered Accident.

This benefit will be paid in addition to any Admission benefits.

For purposes of this benefit, the following Hospital services are not eligible:
- treatment in the Emergency Department;
- treatment on an Outpatient Basis; and
- any Confinement of less than 20 hours.

*Benefit Duration*
This benefit is payable up to a maximum of 365 days per Insured per Covered Accident.

**Short Stay**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured is treated on an Outpatient Basis due to a Covered Accident for minimum of 8 hours in any of the following facilities:
- Ambulatory Surgical Center;
- Emergency Department;
- Hospital; or
- Observation Unit.

The Short Stay must be within 180 days of the Covered Accident.

Benefits for Short Stay will not be paid in addition to any Admission and Daily Stay benefits.

*Benefit Duration*
This benefit is payable up to a maximum of one day per Insured per Covered Accident.

**At-Home Care**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits for each day an Insured receives At-Home Care from a Nurse at the direction of a Physician.

At-Home Care must be prescribed to begin immediately after a Surgical Procedure or period of Confinement due to Injuries sustained in a Covered Accident.

For purposes of this benefit, the following services do not meet the Benefit Description of At-Home Care:

- hospice care; and
- any care provided by you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you.

Benefits for At-Home Care will not be paid for any day that benefits are paid for Admission, Daily Stay or Rehabilitation or Subacute Rehabilitation Unit.

*Benefit Duration*

This benefit is payable up to a maximum of five days per Insured per Covered Accident.

**Behavioral Health Therapy**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits for each day an Insured receives Behavioral Health Therapy due to Injuries sustained in a Covered Accident.

A licensed Mental Health Professional must provide the Behavioral Health Therapy to the Insured.

The therapy must begin within 90 days after the Covered Accident and must be received within 365 days of the Covered Accident.

We will pay either the Physician Follow-Up Visits benefit or the Behavioral Health Therapy benefit for the same Covered Accident if the treatment occurs on the same date by the same Physician. When both treatments occur on the same date by the same Physician, we will pay the benefit with the highest benefit amount.

*Benefit Duration*

This benefit is payable up to a maximum of 15 days per Insured per Covered Accident, up to a maximum of four times per Insured per Calendar year.

**Physician Follow-Up Visits**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured receives:

- initial examination or treatment by a Physician due to Injuries sustained in a Covered Accident more than 14 days after the Covered Accident; or
- follow-up care by a Physician prescribed to occur after the initial examination or treatment due to Injuries sustained in a Covered Accident.

The Physician Follow-up Visit must be within 365 days from the Covered Accident.

For purposes of this benefit, care received in a Physician's office, Hospital, or through Telemedicine meet the Benefit Description of Physician Follow-up Visits.

For purposes of this benefit, routine physical or wellness exams do not meet the Benefit Description of Physician Follow-up Visits.

*Benefit Duration*

This benefit is payable up to a maximum of six visits per Insured per Covered Accident.

**Prescription Drug**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if a Physician prescribes medication to an Insured due to Injuries sustained in a Covered Accident.

Prescriptions must be filled at a pharmacy within 90 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Prescription Drug:
- medication administered while Confined or during a Surgical Procedure;
- medication administered on an Outpatient Basis;
- medication recommended by a Physician that is available without a prescription (over-the-counter);
- refills of a Prescription Drug for which a benefit has previously been paid under this certificate; and
- therapeutic devices or Durable Medical Equipment.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Rehabilitation or Subacute Rehabilitation Unit**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits for each day an Insured is Confined in a Rehabilitation or Subacute Rehabilitation Unit.

The Insured must be transferred to the Rehabilitation or Subacute Rehabilitation Unit for inpatient care immediately after a period of Confinement in a Hospital due to Injuries sustained in a Covered Accident.

Benefits for Rehabilitation or Subacute Rehabilitation Unit will not be paid for any day that benefits are paid for Admission, Daily Stay or At-Home Care.

*Benefit Duration*
This benefit is payable up to a maximum of 15 days per Insured per Covered Accident.

**Therapy Services**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits for each day an Insured receives Therapy Services due to Injuries sustained in a Covered Accident.

A Physician must prescribe the Therapy Services to the Insured on an Outpatient Basis with a Physician or Therapist.

The therapy must begin within 90 days after the Covered Accident and must be received within 365 days of the Covered Accident.

For purposes of this benefit, the following are considered Therapy Services:
- Acupuncture Therapy;
- Alternative Therapy;
- Chiropractic Therapy;
- Occupational Therapy;
- Physical Therapy;
- Respiratory Therapy;
- Speech Therapy; and
- Vestibular Therapy.

For purposes of this benefit, therapy received in a Rehabilitation or Subacute Rehabilitation Unit is considered inpatient and does not meet the Benefit Description of Therapy Services.

*Benefit Duration*
This benefit is payable up to a maximum of 15 days per Insured per Covered Accident.

If more than one type of Therapy Service is received on the same day by the same Physician, we will pay only one day of Therapy Services.

## Accidental Death and Dismemberment Benefits

**Accidental Death**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured dies due to Injuries sustained in a Covered Accident.

The Accidental Death must be within 365 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured.

**Accidental Death - Common Carrier**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured dies while traveling as a fare-paying passenger on a Common Carrier due to Injuries sustained in a Covered Accident.

A Common Carrier is commercial transportation including airplanes, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis and privately chartered vehicles are not common carriers.

The Accidental Death must be within 365 days of the Covered Accident.

*Benefit Duration*
This benefit is payable once per Insured.

**Accidental Dismemberment**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a Dismemberment in a Covered Accident.

The Accidental Dismemberment must be within 365 days of the Covered Accident.

For purposes of this benefit, the following losses meet the Benefit Description of Accidental Dismemberment:
- for the loss of a foot, all of the foot is cut off at or above the ankle joint;
- for the loss of a hand, all four fingers are cut off at or below the knuckles joining each to the hand; and
- for the loss of a thumb and index finger, all of the thumb and index finger are cut off at or below the joint closest to the wrist.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

If an Insured sustains multiple Dismemberments in a single Covered Accident, we will pay for each Dismemberment, but will pay no more than the Employee's Accidental Death benefit amount.

**Coma**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured is in a Coma for a period of seven or more consecutive days due to Injuries sustained in a Covered Accident.

A Coma is a continuous state of profound unconsciousness requiring intubation for respiratory assistance characterized by the absence of:
- eye opening;
- verbal response; and
- motor response.

A Physician must confirm the Coma within 365 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Coma:
- Coma due to stroke; and
- any medically induced Coma.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Home Alterations and Automobile Modifications**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured sustains an Injury due to a Covered Accident, which requires:
- permanent structural alterations that were made to the Insured's primary residence to make it accessible and livable; or
- modifications that were made to a primary Automobile to make it accessible to drive.

The Home Alterations and Automobile Modifications must take place within 365 days of the Covered Accident.

For purposes of this benefit, it is payable if:
- home alterations are recommended by a Physician; or
- modifications to an Automobile are recommended by a Physician, are made by a person or persons with experience in these types of modifications, and modifications are approved by the federal or state vehicle licensing authorities if required.

Benefits for Home Alterations and Automobile Modifications will not be paid until a benefit is first paid for Accidental Dismemberment, Loss of Use, or Paralysis.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

**Loss of Use**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured loses the ability to hear, see, or speak due to Injuries sustained in a Covered Accident.

A Physician must confirm the Loss of Use within 365 days of the Covered Accident.

For the purposes of this benefit, the following losses meet the Benefit Description of Loss of Use:
- for the loss of hearing, total deafness in one or both ears;
- for the loss of sight in one eye, the eye must be totally blind and no sight can be restored in that eye;
- for the loss of sight in both eyes, the:
  - sight in the better eye reduced to a best corrected visual acuity of 20/200 or less (Snellen or E-Chart Acuity);
  - visual field remaining is less than 20° in the better eye; and
  - the Insured was not previously legally blind; and
- for the loss of speech, the ability to speak is a total and irrecoverable loss.

For purposes of this benefit, any loss that can be corrected to any functional degree by any procedure, aid, or device does not meet the Benefit Description of Loss of Use.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

If an Insured sustains multiple losses in a single Covered Accident, we will pay for each Loss of Use, but will pay no more than the Employee's Accidental Death benefit amount.

**Paralysis**

*Benefit Description*
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains Paralysis of one or more limbs in a Covered Accident.

A Physician must confirm the Paralysis within 365 days of the Covered Accident.

For the purposes of this benefit, the following types of Paralysis meet the Benefit Description of Paralysis:

- for Uniplegia, the total and irreversible paralysis of any one limb;
- for Hemiplegia, the total and irreversible paralysis of both limbs on either side of the body, for example the right arm and right leg, or the left arm and left leg;
- for Paraplegia, the total and irreversible paralysis of any two limbs;
- for Triplegia, the total and irreversible paralysis of any three limbs; and
- for Quadriplegia, the total and irreversible paralysis of all four limbs.

*Benefit Duration*

This benefit is payable once per Insured per Covered Accident.

**Exclusions**

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- an occupational Injury;
- any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it. The Mental or Nervous Disorders exclusion does not apply to the Behavioral Health Therapy benefit when the condition is due directly to a Covered Accident;
- infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

**Continuity of Coverage**

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date of this certificate.

Coverage is subject to payment of premium and all other terms of this certificate. If you are on a Leave of Absence on the Policy Effective Date of this certificate, we will consider your Leave of Absence to have started on that date and coverage will continue for the period provided for Leave of Absence under Continuation of your Coverage During Extended Absences in this certificate.

If you have not returned to Active Employment before any Insured's Covered Loss, any benefits payable will be limited to what would have been paid by the prior carrier.

**Newborn Coverage Feature**

Your newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered, and you do not need to notify us or pay any additional premium for the newly eligible Child.

**Waiting Period**

The continuous period of time you must be in an Eligible Group before you are eligible for coverage:

If you are in an Eligible Group on or before November 1, 2025: 60 days
If you enter an Eligible Group after November 1, 2025: 60 days

**Coverage Eligibility Date**

*For you*

If you are in an Eligible Group, you are eligible for coverage on the later of:
- the Policy Effective Date; or
- the day after any applicable Waiting Period has been satisfied.

*For your Spouse*

If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Spouse.

*For your Children*

If you elect coverage for yourself, your Children are eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire the Child.

**Enrolling for Coverage**

**Initial Enrollment**

*Contributory Coverage*

You may apply for any coverage available for you, your Spouse, and Children within 31 days of an Insured's Coverage Eligibility Date.

**Late Enrollment**

*Contributory Coverage*

If you did not apply for coverage during an Insured's Initial Enrollment or you voluntarily cancelled coverage for an Insured and are re-applying, you may apply for coverage during any scheduled Enrollment Period.

**Applying for Changes in Coverage**

*Contributory Coverage*

You may cancel coverage for an Insured at any time during the Policy Year, during any scheduled Enrollment Period, or within 31 days of a Qualifying Life Event.

**Coverage Effective Date**

**Initial Enrollment**

*Contributory Coverage*

Coverage for an Insured will begin on the first day of the month coincident with or next following the later of:
- the Insured's Coverage Eligibility Date if you apply on or before that date; or
- the date you apply for the Insured's coverage, if coverage is applied for within 31 days of the Insured's Coverage Eligibility Date.

**Late Enrollment**

*Contributory Coverage*

Coverage for an Insured will begin on the first day of the next Policy year.

**Coverage Effective Date for Changes in Coverage**

*Contributory Coverage*

A cancellation in coverage made during a scheduled Enrollment Period will begin on the first day of the next Policy Year.

A cancellation in coverage made due to a Qualifying Life Event will begin on the later of:
- the first day of the month coincident with or next following the date of a Qualifying Life Event, if you apply for the cancellation in coverage on or before that date; or
- the first day of the month coincident with or next following the date you apply for the cancellation in coverage if you apply within 31 days of the Qualifying Life Event.

A cancellation in coverage made at any time during the Policy Year will begin on the first day of the month coincident with or next following the date you apply for the cancellation coverage.

Any cancellation in coverage will not affect a Payable Claim that occurs prior to the cancellation.

**Coverage Effective Date if you are not in Active Employment**

You must be in Active Employment in order for coverage to become effective for any Insured in accordance with the Coverage Effective Date provision.

If you are not in Active Employment due to an Injury, Sickness, or Leave of Absence on the date coverage would become effective, the Insured's Coverage Effective Date will be the date you return to Active Employment.

Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage is subject to this provision.

A delay of Coverage Effective Date for a change in coverage will not affect coverage that is currently in force.

**Continuation of Your Coverage During Extended Absences**

*Leave of Absence, other than a Family and Medical Leave of Absence*

You will be covered through the end of the month following 3 months from the date your Leave of Absence begins, provided premium is paid.

*Family and Medical Leave of Absence*

We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical leave of absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Waiting Period.

*Injury or Sickness*

You will be covered for up to 3 months from the date your absence due to an Injury or Sickness begins, provided premium is paid.

**End of Coverage**

*For you*

If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the earliest of:

- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue:

- in accordance with the Continuation of your Coverage During Absences provision; or
- if you elect to continue coverage for you under Portability of Accident Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

*For your Spouse*

If, while your coverage is in force, you choose to cancel your Spouse's coverage under this certificate, your Spouse's coverage will end on the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end on the earliest of:

- the date your coverage under this certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse may elect to continue Spouse and Children coverage, as long as premium is paid as required under Portability of Accident Insurance.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered

under this certificate.

*For your Children*

If, while your coverage is in force, you choose to cancel your Children's coverage under this certificate, your Children's coverage will end on the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Children's coverage will end on the earliest of:

- the date your coverage under this certificate ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this certificate.

**Filing a Claim**

We encourage early notification of a claim for benefits under this certificate so that a claim decision can be made in a timely manner. If there are any questions on how to file a claim, please contact us or your Employer.

*Step 1 - Starting a Claim*

Notice of a claim may be provided in Writing, online at: **services.unum.com**, or by contacting us directly at 1-800-858-6843. Notice of a claim should be provided within 20 days from the date of the Covered Loss, or as soon as reasonably possible. If it is not reasonably possible to provide notice within this time period, it will not affect a Payable Claim if it is provided as soon as is reasonably possible.

*Step 2 - Claim Forms*

After receiving notice of a claim, we will send a claim form to you or your authorized representative within 15 days from the date we receive the notice of a claim. Claim forms may also be available from your Employer or from us online at: **services.unum.com**.

When you or your authorized representative receive the claim form, you or your authorized representative must fill out your own section of the claim form and provide the Insured's Physician with the applicable section of the claim form. The Insured's Physician should complete their section of the form and send it directly to us.

If you or your authorized representative do not receive a claim form from us within 15 days after we receive notice of a claim, a Written statement from you or your authorized representative as to the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be sent to us by mail or fax:

Mailing Address: The Benefits Center
P.O. Box 100158
Columbia, South Carolina 29202-3158
Fax: 1-800-447-2498

*Step 3 - Proof of Loss*

Proof of Loss must be sent to us no later than 90 days after the date of Covered Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it will not affect a Payable Claim if it is provided within one year, unless the Insured lacks the legal capacity to do so.

In no event can Proof of Loss be submitted after the expiration of the time limit for commencing Legal Action as stated in this certificate, even if the failure to provide Proof of Loss is due to a lack of legal capacity or if state law provides an exception to the one year time period.

Proof of Loss, provided at your or your authorized representative's expense, must establish the nature and extent of the Covered Loss and should include but not be limited to the following:

- the cause of death or Covered Loss;
- the extent of the Covered Loss;
- the date of Covered Loss;
- the name and address of any Hospital or institution where treatment was received, including all attending Physicians; and
- in case of death, a certified copy of the death certificate or other lawful evidence providing equivalent information.

If the Proof of Loss is not complete, we will request additional information.

**Authorization for Release of Information**

We may request Written authorization from an Insured. This authorization may be required in order for us to obtain the necessary medical and non-medical information needed for Proof of Loss. This information may include any appropriate financial records such as income tax returns. Failure to provide us with Written authorization may result in

the denial of a claim if the Insured does not send proof to us and we are not able to obtain the proof that is required to make a claim decision.

**Right to Exam, Test, or Interview**

We may ask the Insured to be examined or tested by one or more Physicians, other medical practitioners, or vocational experts of our choice. We may also require the Insured to be interviewed by an authorized representative of ours.

We have the right to request exams or tests as often as it is reasonably necessary. Any exam, test, or interview that we require will be paid at our expense. If the Insured fails to attend or fully participate, we will not pay the benefits or we will stop sending benefits under this certificate.

**Autopsy**

We will have the right, at our expense, to request an Autopsy where it is allowed by law.

**Claim Procedures**

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a claim decision and issue payment for a Payable Claim in accordance with the Payment of Benefits provision.

If we determine additional time is needed to review a claim, we may extend this time period by 30 days. We will notify the Insured of the circumstances requiring a review extension and when we anticipate making a claim decision.

If a claim for benefits under this certificate is wholly or partially denied, we will provide notice of our decision in Writing. The notice will contain the following information:

- the specific reason(s) for the determination with reference to those provisions on which the decision is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary;
- procedures and time limits for appealing our decision, and the Insured's right to obtain information about those procedures;
- a statement describing the right to bring a lawsuit under Section 502(a) of ERISA following a claim determination; and
- a statement disclosing any internal rule, guidelines, protocol, or similar criteria used in making the decision (or a statement that such information will be provided free of charge upon request).

**Payment of Benefits**

Benefits for which we are liable will be paid immediately or within 30 days after we receive Written Proof of Loss. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

**Beneficiary Designation and Change**

When a person becomes insured under this certificate, the Insured is responsible for designating a beneficiary in Writing for any benefits due in the event of the Insured's death. It is important to list the full name of each beneficiary and that all beneficiary designations are kept current and provided to us or the Employer. A beneficiary designation form may be available from the Employer or from us online at: **services.unum.com**.

You are the Beneficiary for any Insured under this certificate while you are still living unless there is a valid change in beneficiary designation by an Insured. If an Insured wishes to change their beneficiary designation, they may do so by sending us or the Employer a completed, dated, and signed beneficiary designation change form. Changes in beneficiary designations will take effect on the date notice of the beneficiary designation is signed by the Insured.

Payment of Benefits will be administered based upon the currently available beneficiary designation on file with us or the Employer. If we have taken any action or made any payment before receiving notice of a beneficiary designation, that beneficiary designation will not go into effect for those actions taken or payments made.

If more than one beneficiary is named and the order or share of payments is not designated, the beneficiaries will share equally. The share of a beneficiary who dies before an Insured, the share of a beneficiary who is legally unable to receive benefits, or the share of benefits that are unallocated will pass to any surviving beneficiaries in proportion to their current allocations. The aggregated shares of benefits in excess of 100% will be deducted from surviving beneficiaries in proportion to their current allocations.

If a beneficiary is not named, or if all named beneficiaries do not survive the Insured, or the named beneficiary is legally unable to receive benefits, any benefits due will be paid to the first surviving family member in the order that follows:
- you;
- the Insured's Spouse;
- the Insured's natural offspring and legally adopted children in equal shares;
- the Insured's mother or father in equal shares, if paying both; or
- the Insured's sisters and brothers in equal shares.

Instead of making a payment to a surviving family member, we have the right to pay any benefits due to the Insured's estate. If there are no surviving family members, any benefits due will be paid to the Insured's estate.

In the event of your death, should your Spouse survive you and elect to continue coverage under Portability of Accident Insurance, your surviving Spouse should name a beneficiary according to the requirements specified within this provision.

**Payments to a Minor or Incompetent Insured or Insured's Beneficiary**

If an Insured or an Insured's beneficiary is a minor or is incompetent, we can pay up to $5,000 to the person or institution that appears to have assumed the custody and main support of the Insured, the minor, or the Insured's beneficiary unless or until that Insured, the minor, or the Insured's beneficiary's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again.

**Overpayment of Claims**

We have the right to recover any overpayments due to:
- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

We will not recover more money than the amount we paid you.

**Unpaid Premium**

Any Unpaid Premium due for an Insured's coverage at the time of payment for a claim may be deducted from the Insured's claim payment.

**Appeal Procedures**

Any request to file an appeal of a wholly or partially denied claim must be sent to us in Writing within 180 days from the date of Written notice of our claim decision. You have the right to:
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit Written comments, documents, records, and other information relating to the claim to us.

Once we receive an Insured's appeal request, it will be assigned to an appeals specialist. The appeals specialist is a person different from the person who made the initial

determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, we will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained in connection with the denial of an Insured's claim, we will provide the Insured with the names of each such expert, regardless of whether the advice was relied upon.

We will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. We will notify the Insured of the appeal decision within 45 days from receipt of the Written request for review. If we determine additional time is needed to review the appeal request, we may extend this time period by an additional 45 days. We will notify the Insured if an extension is needed.

If any review extension is necessary due to the Insured's failure to provide the information necessary to make a decision, we will notify the Insured of the review extension and specifically describe what information is required. This information must be sent to us within the time specified from the date of our request. The 45 day review extension will begin on the date we receive the requested information.

If the Insured fails to provide us with the requested information within the specified time period, we will make a decision based on the information available to us at that time.

If an appeal is wholly or partially denied, we will provide notice in Writing. Notice of a denied appeal will contain the following information:

- the specific reason(s) for the denial with reference to those provisions on which the denial is based;
- a statement disclosing any internal rule, guidelines, protocol, or similar criteria used in making the decision (or a statement that such information will be provided free of charge upon request);
- a statement describing the right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the appeal decision;
- a statement that entitles the Insured, at their request, reasonable access to or copies of all documents, records, or other information relevant to the appeal decision free of charge; and
- the statement that "You or 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."

Unless there are special circumstances, this administrative appeal process must be completed before an Insured begins any Legal Action regarding a claim.

**Legal Actions**

The time limit on Legal Actions for a Covered Loss is subject to applicable law in the state where the Policy was issued.

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:

- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless otherwise provided under federal law.

**When Days Begin and End**

For the purpose of all dates under this Certificate of Coverage, all days begin at 12:01 a.m. and end at 12:00 midnight.

**Certificate of Coverage Contents**

Coverage for an Insured is provided under this Certificate of Coverage which is a part of the Policy issued to the Policyholder. The Policy consists of:

- all Policy provisions, and any riders, amendments and endorsements, and other attachments to the Policy;
- this Certificate of Coverage, and any riders, amendments and endorsements, and other attachments to this Certificate of Coverage;
- the Policyholder's application for group insurance; and
- Employee's signed applications, if applicable.

**Your Certificate of Coverage**

We will provide the Employer with a Certificate of Coverage for distribution to each Insured Employee. Your certificate describes:

- the coverage to which an Insured may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions, and requirements that apply to an Insured's coverage.

If any of the terms and provisions of this certificate are different than in the Policy, the Policy will govern.

**Cancellation or Modification to the Policy and this Certificate of Coverage**

The Policy and this Certificate of Coverage may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the Policy or certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.

All Policy and certificate modifications will take effect according to the Coverage Effective Date for Changes in Coverage provision.

**Representation in Applications**

Any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary.

**Assignment**

An Assignment transfers all or part of your legal title and rights under the Policy and this certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the Policy and this certificate if:

- the Written form has been signed by you and the assignee and the form is acceptable to us; and
- a signed or certified copy of the Written Assignment has been filed with us.

An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. An Assignment does not change an Insured's coverage or beneficiary designation.

We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.

**Contestability**

We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of Fraud, we can take Legal Action at any time as permitted by applicable law.

**Misstatement of Information**

If you or your Employer provides us information about an Insured that is incorrect, we will:

- use the facts to decide whether the Insured has coverage under this certificate and the Policy and in what amounts; and
- if necessary, make the applicable premium adjustments.

**Fraud**

We want to make sure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if anyone knowingly, and with intent to injure, defrauds, or deceives us. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

**Agency**

For purposes of the Policy, your Employer acts on their own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

**Workers' Compensation or State Disability Insurance**

This certificate does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**Communicating With you or your Employer**

We may provide notices, information, and other communications to you or your Employer in Written form.

To protect our customers, we will abide by all applicable privacy laws and regulations.

**Additional Services**

This certificate may include enrollment, risk management, financial protection, and other support services related to your Employer's benefit program.

**Active Employment**

You are working for your Employer for earnings that are paid regularly and you are performing the Material and Substantial Duties of your Regular Occupation. You must be regularly scheduled to work at least the minimum number of hours as determined by your Employer.

Your work site must be:
- your Employer's usual place of business in the United States;
- an alternative work site in the United States at the direction of your Employer; or
- a location in the United States to which your job requires you to travel.

Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.

For purposes of this certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:
- inclement weather;
- power outage; and
- public health agency orders.

Temporary and seasonal workers are excluded from coverage.

**Acupuncture Therapy**

The practice of penetrating the skin with thin, solid, metallic needles, which are then activated through gentle and specific movements of the practitioner's hands or with electrical stimulation.

**Alternative Therapy**

Treatment that includes, but may not be limited to:
- biofeedback; or
- electrical stimulation.

**Ambulatory Surgical Center**

A facility, separate from a Hospital, equipped for Physicians to perform Surgical Procedures on an Outpatient Basis and must:
- provide anesthesia administered by a licensed anesthesiologist or licensed nurse anesthetist; and
- have agreements with local Hospitals to immediately accept patients who develop complications.

**Automobile**

A private passenger motor vehicle, also referred to as "auto," which is licensed for use on public roads and highways, and is subject to motor vehicle registration. The term Automobile does not include an All-Terrain Vehicle (ATV), motorcycle, scooter, or golf cart.

**Behavioral Health Therapy**

The treatment of an Insured by a Mental Health Professional.

**Calendar Year**

The period beginning on the Insured's Coverage Effective Date and ending on December 31 of the same year. For each following year, it is the period beginning on January 1 and ending on December 31.

**Certificate of Coverage**

The document issued to the Employee, also referred to as the "certificate," describing an Insured's benefits and rights under the Policy, including any riders, amendments and endorsements, and other attachments to this certificate and the Policy.

**Child Care Center**

Any facility or private care that:
- is licensed as such by the state,
- provides non-medical care and supervision for Children; and
- is not operated by you or a Family Member.

**Childbirth**

Birth of a child by routine vaginal delivery or non-emergency Cesarean section.

Childbirth or Complications of Pregnancy will be treated as any other Sickness.

**Children**

Any child from the moment of birth to age 26 who is:
- your own natural offspring;
- your stepchild;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- any child subject to your legal guardianship; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

**Chiropractic Therapy**

Spinal manipulation services conducted by a licensed chiropractor to correct a structural imbalance.

For purposes of this certificate, the following services do not meet the Glossary definition of Chiropractic Therapy:
- massage therapy;
- treatment of chronic conditions; and
- other Injuries not related to structural imbalance.

**Complications of Pregnancy**

Abnormal conditions or concurrent diseases that significantly affect the pregnancy's usual medical management. A complication may exist during the pregnancy, during the birth, or after the birth.

Childbirth or Complications of Pregnancy will be treated as any other Sickness.

**Confined** or **Confinement**

Assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, for a minimum of 20 continuous hours on the advice of a Physician.

**Contributory Coverage**

Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.

**Covered Accident**

An accident that is not specifically excluded by name or specific description in this certificate. The loss for which a claim is made must occur on or after the Insured's Coverage Effective Date.

**Covered Loss**

An accidental death, dismemberment, loss, or other Injury for which benefits are payable under this certificate.

**Emergency Department**

A specified area within a Hospital, or standalone facility that is affiliated with a Hospital, designated for the emergency care of accidental Injuries or Sicknesses. This area must:
- be staffed and equipped to handle trauma;
- be supervised and have treatment provided by Physicians; and
- provide care seven days per week, 24 hours per day.

**Employee** A person, also referred to as "you," who is in Active Employment in the United States with the Employer.

**Employer** The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.

**Enrollment Period** A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.

**Family Member** A Child, stepchild, Spouse, parent, stepparent, sibling, stepsibling, parent-in-law, Child-in-law, sibling-in-law, grandparent, grandparent's Spouse, grandchild, or grandchild's Spouse.

**Felonious Act of Violence** An act of violence that is considered a felony where the act occurred. Felonious Acts of Violence include, but are not limited to:
- assault and battery;
- civil disturbance;
- hijacking;
- murder;
- sniping; and
- theft.

**Hospital** A licensed institution supervised by Physicians and operated pursuant to law on a full-time basis. The Hospital must:
- provide overnight care to people with Injuries or Sicknesses;
- have full-time Nurses on duty or on call who are supervised by a registered Nurse; and
- have X-ray equipment, a laboratory, and a surgical operating room at its locations or available to use on a pre-arranged basis.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation or Subacute Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

**Injury** Any damage or harm to the body that is the direct result of an accident and not related to any other cause.

**Insured** Any person who has coverage under this certificate.

**Leave of Absence** Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.

Normal vacation time, holidays, or temporary business closures are not considered a Leave of Absence.

**Material and Substantial Duties** Duties that:
- are routinely required for the performance of your Regular Occupation; and
- cannot be reasonably omitted or modified.

**Mental Health Professional** A healthcare professional licensed by the state to practice and provide Behavioral Health Therapy. Any Mental Health Professional must be acting within the scope of their

license. A Mental Health Professional does not include an Insured or a Family Member.

**Mental or Nervous Disorders** — A psychiatric or psychological condition classified in the most recent *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) published by the American Psychiatric Association (APA), as of the date of Covered Loss. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the APA as of the date of Covered Loss. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, we will use a comparable diagnostic manual.

**Nurse** — A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Family Member, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us.

**Observation Unit** — A specified area within a Hospital, separate from the Emergency Department, where a patient can be monitored following a Surgical Procedure performed on an Outpatient Basis or treatment in the Emergency Department. The Observation Unit must:
- be under the direct supervision of a Physician or registered Nurse;
- be staffed by Nurses assigned specifically to that unit; and
- provide care seven days per week, 24 hours a day.

**Occupational Therapy** — The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

For purposes of this certificate, the following do not meet the Glossary definition of Occupational Therapy:
- diversional therapy;
- recreational therapy; and
- any vocational therapies (e.g. hobbies, arts, and crafts).

**Organized Sports** — A competition or supervised sport governed by an organization that requires formal registration to participate and is officiated by someone certified to act in that capacity.

**Outpatient Basis** — Medical care and treatment received without being admitted to a Hospital or other facility.

**Payable Claim** — A claim for which we are liable for under the terms of this certificate.

**Pet** — A domestic animal that lives with an Insured and is dependent on the Insured for primary care and maintenance.

**Pet Boarding Facility** — An appropriately licensed independent animal care provider or facility specializing in the care and overnight or long-term boarding of animals that is not owned or operated by an Insured or a Family Member.

**Physical Therapy** — Treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical, and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following Injury or loss of a body part.

**Physician** — A person performing tasks that are within the limits of his or her medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Family Member, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

**Plan** Your Employer's Accident Welfare Benefit Plan under ERISA which includes this certificate, your Employer's Group Accident Insurance Policy, and other benefit plan documents consistent with this Plan.

**Policy** The Group Accident Insurance Policy issued to the Policyholder, including this Certificate of Coverage and any riders, amendments and endorsements, and other attachments to this certificate and the Policy.

**Policyholder** The entity to which the Policy is issued.

**Qualifying Life Event** For coverage determination purposes, a Qualifying Life Event means an event including, but not limited to:
- birth, adoption, or addition of a Child;
- a change in legal marital status;
- a change in employment status; or
- death of an Insured.

Qualifying Life Event coverage changes made in accordance with the Start of Coverage provisions must be consistent with the Qualifying Life Event.

For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy.

**Regular Occupation** The occupation you are routinely performing. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer at a specific location.

**Rehabilitation Unit** An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. The care services provided by the Rehabilitation Unit must:
- consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by accidental Injury or Sickness to achieve the highest possible functional ability; and
- be provided by or under the supervision of an organized staff of Physicians.

The Rehabilitation Unit may be part of a Hospital or a standalone facility.

For purposes of this certificate, the following do not meet the Glossary definition of Rehabilitation Unit:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Subacute Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

**Respiratory Therapy** Treatment and assistance used to recover lung function.

**Sexual Assault** Any nonconsensual sexual act proscribed by federal, tribal, or state law, including when the victim lacks capacity to consent.

**Sickness** An illness or disease.

**Speech Therapy** Treatment and assistance for disorders related to speech, language, cognitive-communication, voice, swallowing, and fluency.

**Spouse** The person who is your partner through lawful marriage, civil union, domestic partnership

(established by a declaration acceptable to us), or your legally separated Spouse.

Your Spouse may not be Insured as both a Spouse and an Employee.

**Subacute Rehabilitation Unit**

A licensed facility or distinct part of a facility supervised at all times by a Physician or Nurse. The facility must provide care to people with Injuries or Sicknesses on an inpatient basis. The Subacute Rehabilitation Unit must have a Physician available at all times and have a transfer agreement in effect with one or more participating Hospitals.

For purposes of this certificate, the following do not meet the Glossary definition of Subacute Rehabilitation Unit:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

**Substance Abuse**

Abuse of or addiction to drugs or alcohol.

**Surgical Procedure**

The cutting into the skin or other organ to accomplish any of the following goals:
- further explore the condition for the purpose of diagnosis;
- take a biopsy of a suspicious lump;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- repair an area that has been injured or affected by trauma, overuse, or Sickness; or
- restore proper function.

For purposes of this certificate, the following do not meet the Glossary definition of Surgical Procedure:
- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags; and
- foreign body removal from the eye.

**Telemedicine**

A medical inquiry with a Physician via the use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the Insured's evaluation, diagnosis, or treatment as would be practiced in person. This does not include requests for prescription refills or medical records.

**Therapist**

A health care professional appropriately licensed by the state to perform therapy services with the exception of you, your Family Member, a business or professional partner, or any person who has a financial affiliation or business interest with you.

**Unum Insurance Company**

Referred to as "Unum" and "we," "us," or "our."

**Urgent Care Facility**

A health care facility that is organizationally separate from a Hospital with the primary purpose of offering and providing urgent and immediate, short-term medical care, without an appointment.

**Vestibular Therapy**

Treatment and assistance for balance and dizziness problems, and vestibular disorders.

**Writing** or **Written**

A record on or transmitted by paper, electronic, or telephonic means consistent with applicable law.

## IMPORTANT NOTICES

**Questions regarding your policy or coverage should be directed to:**

**Unum Insurance Company**
**(877) 225-2712**

If you:
(a). need the assistance of the governmental agency that regulates insurance; or
(b). have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

**Unum Insurance Company**
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

## Be Well Benefit

We encourage our Insureds to maintain a healthy lifestyle. For those who take precautionary measures by receiving routine health screenings, we offer a Be Well Benefit. This is an annual cash benefit that may be claimed after completing an eligible Be Well Screening, and may be used to help with monetary expenditures such as transportation, missed work, or other incidentals.

For the purpose of determining your coverage and eligibility for the Be Well Benefit, all terms and provisions of your Certificate of Coverage apply unless modified below.

**Policyholder:** Forest River, Inc.

**Policy Number:** 984567 012

**Policy Effective Date:** November 1, 2025

**Be Well Benefit Effective Date:** November 1, 2025

**Eligible Group(s)**

All Full Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

**Paying for Coverage**

The Be Well Benefit is automatically included in the cost of your Accident Insurance coverage.

**Be Well Benefit**

| For you | For your Spouse | For your Children |
|---|---|---|
| $50 | $50 | $50 |

**Be Well Benefit Payment Conditions**

Each Insured is eligible to receive a maximum of one Be Well Benefit per Calendar year.

The Be Well Benefit will become payable provided the following conditions are met:
- the date of the Be Well Screening is after the Be Well Benefit Effective Date; and
- an Insured's coverage is in force.

**Be Well Screenings**

| | |
|---|---|
| Cholesterol and Diabetes | Eligible screenings include, but may not be limited to: blood test for triglycerides, fasting plasma glucose (FPG), fasting blood glucose test, hemoglobin A1C(HbA1c), Serum cholesterol test to determine total, HDL and LDL cholesterol levels, two hour post-load plasma glucose. |
| Cancer | Eligible screenings include, but may not be limited to: colonoscopy, virtual colonoscopy, CEA (blood test for colon cancer), low-dose computerized tomography (CT) (imaging study for lung cancer), double-contrast barium enema, fecal immunochemical testing, fecal DNA testing, PSA (blood test for prostate cancer), bone marrow testing, serum protein electrophoresis (blood test for myeloma), dermatological screenings for skin cancer, flexible sigmoidoscopy, hemoccult stool analysis, pap smear, thin prep pap test, cytology |

| | |
|---|---|
| | (PAP) smear, CA 15-3 (blood test for breast cancer), CA-125 (blood test for ovarian cancer), BRCA1 or BRCA2 testing. |
| Cardiovascular Function | Eligible screenings include, but may not be limited to: echocardiogram, electrocardiogram, stress test on a bicycle or treadmill, myocardial perfusion imaging. |
| Imaging Studies | Eligible screenings include, but may not be limited to: chest x-ray, carotid ultrasound (Doppler), mammography, breast ultrasound, breast MRI, breast thermography, transvaginal ultrasound, bone density scans, aortic ultrasound. |
| Annual Examinations by a Physician | Eligible examinations include sports physicals, annual exams for adults, and well-child visits. |
| Immunizations | Eligible immunizations include, but may not be limited to: HPV, Hepatitis B, chicken pox, MMR, meningitis, tetanus, pneumonia, influenza. |

**Unum Insurance Company**
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

# Portability of Accident Insurance

Portability allows you, your Spouse, and Children to continue coverage when coverage under the Employer's group Policy would otherwise end due to an Eligible Portability Event. The certificate in force at the time of an Insured's Eligible Portability Event will reflect the terms and conditions of the coverage that can be continued.

Portability of Accident Insurance is made a part of the Accident Insurance Policy and is subject to all of the provisions, limitations and exclusions of the Policy and certificate, unless changed by this document. Additionally, defined terms found within Portability of Accident Insurance have been capitalized and have the same meaning as the terms in the Glossary section of the Certificate of Coverage.

Any future changes made in the Employer's group Policy will not apply to coverage an Insured has ported, unless required by law.

If you have any questions about portable coverage, please contact your Employer or us.

**Policyholder:** Forest River, Inc.

**Policy Number:** 984567 012

**Policy Effective Date:** November 1, 2025

**Portability Effective Date:** November 1, 2025

## Portability Provisions

**Eligible Portability Events**

You are eligible to port coverage on the date of the following Eligible Portability Events:
- your employment with your Employer ends; or
- you are no longer in an Eligible Group.

However, you will not be considered eligible to port coverage at the time of an Eligible Portability Event if the Employer's Policy is cancelled by us.

**Portable Coverage Available**

The amount of coverage in force for each Insured on the date of your Eligible Portability Event is available to port subject to the following:

*For you*
The maximum amount of coverage available to port is your in force coverage at the time of your Eligible Portability Event.

*For your Spouse*
The maximum amount of coverage available to port is your Spouse's in force coverage at the time of your Eligible Portability Event.

*For your Children*
The maximum amount of coverage available to port is your Children's in force coverage at the time of your Eligible Portability Event.

If you wish to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time you apply for portable coverage.

**Applying for Portable Coverage**

If you choose to apply for portable coverage for yourself, you may also port coverage for your Spouse and/or Children.

You must apply for portable coverage and pay the first premium within 31 days from the date of an Eligible Portability Event.

Applications for Portability are available from your Employer.

**Ported Coverage Effective Date**

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under your Employer's Policy.

**Changes to Ported Coverage**

You may decrease coverage for an Insured at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

**End of Ported Coverage**

If you choose to cancel your ported coverage, coverage for all Insureds will end on the first of the month following the date you provide notification to us.

*For you*

Otherwise, your ported coverage will end on the earliest of:

- the date you fail to pay the required premium within 31 days of a premium due date;
- the date you are rehired by your Employer or return to an Eligible Group and are covered under the Employer's group Policy;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice; or
- the date you die.

*For your Spouse*

Your Spouse's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse has the option to port coverage in accordance with Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment.

*For your Children*

Your Children's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event your Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Accident Insurance prior to the Employer's group Policy termination date will not be affected.

**Paying for Ported Coverage**

You must make all premium contributions for ported coverage. We will bill you directly for any premium due.

**Rates for Ported Coverage**

Premium will be based on the rates for Portability in effect on the date you apply to port coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

## Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment

**Eligible Portability Events for your Spouse**

Your Spouse is eligible to port Spouse and Children coverage on the date of the following Eligible Portability Events for your Spouse:

- your death; or
- divorce or annulment.

**Portable Coverage Available**

The amount of coverage in force for each Insured, on the date of the Eligible Portability Event for your Spouse, is available to port subject to the following:

*For your Spouse*

The maximum amount of coverage available to port is your Spouse's in force coverage at the time of the Eligible Portability Event for your Spouse.

*For your Children*

The maximum amount of coverage available to port is your Children's in force coverage at the time of the Eligible Portability Event for your Spouse.

If your Spouse wishes to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time your Spouse applies for portable coverage.

**Applying for Portable Coverage**

If your Spouse chooses to apply for portable Spouse coverage, your Spouse may also apply for portable Children coverage.

Your Spouse must apply for portable coverage and pay the first premium within 31 days from the date of the Eligible Portability Event for your Spouse.

Applications for Portability are available from us.

**Ported Coverage Effective Date**

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under the Employer's Policy.

**Changes to Ported Coverage**

Your Spouse may decrease their Spouse and Children coverage at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

**End of Ported Coverage**

If your Spouse chooses to cancel ported coverage, your Spouse and Children's coverage will end on the first of the month following the date your Spouse provides notification to us.

*For your Spouse*

Otherwise, your Spouse's ported coverage will end on the earliest of:

- the date your Spouse fails to pay the required premium within 31 days of a premium due date;
- the date your Spouse is no longer eligible for coverage;
- the date coverage provided under Portability is cancelled by us for any reason upon

45 days notice; or
- the date of your Spouse's death.

*For your Children*

Your Children's ported coverage will end on the earliest of:
- the date your Spouse's ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event the Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Accident Insurance prior to the Employer's group Policy termination date will not be affected.

**Paying for Ported Coverage**

Your Spouse must make all premium contributions for Spouse and Children ported coverage. We will bill your Spouse directly for any premium due.

**Rates for Ported Coverage**

Premium will be based on the rates for Portability in effect on the date your Spouse applies to port Spouse and Children coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

## GROUP ACCIDENT

**THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.**

State variations apply and are subject to change. Consult your Employer or plan administrator for the most current state provisions that may apply to you.

**Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.**

If you have a complaint about your insurance you may contact us at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene una queja acerca de su seguro puede comunicarse con nosotros a traves del numero 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of these states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

**If you are a resident of one of the states noted below, and the provisions referenced below appear in your certificate in a form less favorable to you as an Insured, they are amended as follows:**

---

### For residents of Arkansas

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from active participation in a riot, insurrection, or terrorist activity. This exclusion is amended by removing "or terrorist activity".

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

> **Newborn Coverage Feature**
> Your newborn or newly adopted Children will automatically be covered for 60 days from their Coverage Eligibility Date if you are insured.
>
> If you wish to continue Child coverage, you must notify us and pay any additional premium.
>
> If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Initial Enrollment** language in the **Enrolling for Coverage** provision in the **Start of Coverage** section of the certificate is amended for Children so that you can apply for their coverage within 90 days.

The **Initial Enrollment** language in the **Coverage Effective Date** provision in the **Start of Coverage** section of the certificate is amended for Children so that if coverage for a newly acquired Child is applied for within 90 days of the Child's Coverage Eligibility Date, coverage will begin on the Child's Coverage Eligibility Date, provided premiums are paid.

The **Children** definition in the **Glossary** section of the certificate is amended for a Child who is incapable of self-sustaining employment due to permanent intellectual or physical incapacity as follows:

> Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the Child's incapacity and dependency to us in order to continue coverage that would have otherwise ended due to age. Ongoing proof of incapacity and dependency must be provided, at our expense, when requested by us.

## For residents of Colorado

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

## For residents of Idaho

The **Exclusions** provision in the **Accident Details** section of the certificate is amended as follows:

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- participation in a felony;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of congenital disease or anomaly of a covered dependent child;
- an occupational Injury;
- Mental or Nervous Disorders. The Mental or Nervous Disorders exclusion does not apply to the Behavioral Health Therapy benefit when the condition is due directly to a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member as a professional of any aircraft or hot air balloon as a professional, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight as a professional in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
- practicing for or participating in any professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a professional race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping as a professional.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

**Newborn Coverage Feature**
Your newborn or newly adopted Children will automatically be covered for 60 days from the moment of live birth if you are insured.

Coverage will only continue if you notify us and enroll your Child for coverage on or before the end of the 60 day period. The appropriate premium (if any) must be received by us within 31 days of the date the monthly premium invoice is received by the Policyholder and a notice of premium (if any) is provided to the Employee.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Claim Procedures** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim happens immediately.

A **Congenital Anomalies** definition has been added to the **Glossary** section of the certificate as follows:

Conditions existing at or from birth that are a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. Significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

**For residents of Indiana**

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid immediately or within 30 days after receipt of satisfactory Written Proof of Loss.

The **Children** definition in the **Glossary** section of the certificate is amended as follows:

Any child from moment of birth to age 26 who is:
- your own natural offspring;
- your stepchild;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- any child subject to your legal guardianship; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

**For residents of Louisiana**

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution is amended so that if the Insured has not been adjudicated or convicted of a criminal offense, this exclusion would not apply.

The **Claim Procedures** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended as follows:

**Payment of Benefits**
Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits. We may be subject to a penalty, payable to you, of double the amount of benefits due to the Insured under the terms of this certificate during the period of delay should we issue any benefit payment after 30 days from the date we receive satisfactory proof. This penalty may also include attorney's fees to be determined by the court.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Children** definition in the **Glossary** section of the certificate for "any other child residing with you through legal mandate that is dependent on you for financial support" is amended as follows:

- any other child, including grandchild, residing with you through legal mandate;

The **Children** definition in the **Glossary** section of the certificate is amended to include any other Child if placed following an execution of an act of voluntary surrender on the date on which the act of voluntary surrender becomes irrevocable.

## For residents of Minnesota

The state of **Minnesota** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Minnesota law. The minimum requirements of Minnesota law will apply to your claim.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not, is amended by removing the phrase, "or attempting or committing suicide".

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from:

- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;

is removed.

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

**Newborn Coverage Feature**
Your newborn or newly adopted Children will automatically be covered from their Coverage Eligibility Date if you are insured.

If you do not have coverage for your Child at the time of birth or adoption, you must pay any required additional premium. If we do not receive premium for your newly eligible Child, we may reduce any benefits payable by the amount of the past due premiums applicable to the additional Child.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to pay any additional premium for the newly eligible Child.

## For residents of Montana

The state of **Montana** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Montana law. The minimum requirements of Montana law will apply to your claim.

The Exclusions provision in the Accident Details section of the certificate for "committing or attempting to commit a felony" is replaced with the following:

- convicted of committing a felony;

The Exclusions provision in the Accident Details section of the certificate for "operating any motorized vehicle while intoxicated" is replaced with the following:

- operating any motorized vehicle while intoxicated. For purposes of this exclusion, "intoxicated" means not having the normal use of mental or physical faculties by reason of the introduction of alcohol, a controlled substance, a drug, or any other substance into the body; or having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended for Accidental Death and Dismemberment Benefits as follows:

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- an Insured being voluntarily intoxicated. For purposes of this exclusion, "intoxicated" means not having the normal use of mental or physical faculties by reason of the introduction of alcohol, a controlled substance, a drug, or any other substance into the body; or having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state; and
- an Insured's voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

**Newborn Coverage Feature**
An Insured's newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Overpayment of Claims** provision in the **Claim Provisions** section of the certificate is amended by limiting the right to recover overpayments to 12 months from the date of payment. This provision reads as follows:

We have the right to recover any overpayments for up to 12 months due to:

- Fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

The 12 months we have to recover overpayments will begin:

- for Fraud, on the date the Department of Insurance (DOI) determines insufficient evidence of Fraud exists. If we suspect a claim is overpaid as the result of Fraud, we will report the activity and evidence to the DOI;
- for reasons other than Fraud, including error, omissions, misstatement, misrepresentation, or concealment of information, on the date we have actual knowledge of the invalid claim, overpayment, or other incorrect payment. We will not request reimbursement of an unpaid claim not the result of

Fraud more than 24 months from the date of payment, regardless of the date we obtain actual knowledge of the invalid claim, overpayment, or other incorrect information.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments upon Written authorization from you.

We will not recover more money than the amount we paid you.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary.

The **Childbirth** definition in the **Glossary** section of the certificate is amended as follows:

Birth of a child by vaginal delivery or Cesarean section.

Childbirth will be treated as any other Covered Sickness.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

**For residents of New Hampshire**

The **Contestability** provision in the **Policy Provisions** section of the Policy is amended to remove reference to Fraud. The last sentence has been replaced to read as follows:

However, in the event of nonpayment of premium by the Insured or the Policyholder, we can take action at any time under the provision titled Cancellation or Modification of this Policy by Us and as permitted by applicable law.

The **Burns** benefit in the **Accident Highlights** section of the certificate is amended to add a new skin surface benefit to read "Less than 5% of skin surface."

The **Loss of a Digit** benefit in the **Accident Highlights** section of the certificate is amended to reflect a specific dollar amount in the Schedule of Benefits as follows: the greater of the amount elected by the employer or $1,000 for one digit or $2,000 for two or more digits.

The **Accidental Death and Accidental Death - Common Carrier** benefits in the **Accident Highlights** section of the certificate are amended to reflect a specific dollar amount for Spouses and Children in the Schedule of Benefits as follows: the greater of the amount elected by the employer or $5,000.

The **Loss of a Digit** benefit in the **Accident Details** section of the certificate is amended to remove the paragraph describing the physical limitations for the Benefit Description.

The **Injections to Prevent or Limit Infection** benefit in the **Accident Details** section of the certificate is mended to remove the criteria that does not meet the Benefit Description.

The **Pain Management Injections** benefit in the **Accident Details** section of the certificate is amended to remove the criteria that does not meet the Benefit Description.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended a follows:

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
- participation in a felony;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;

- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other disease;
- an occupational Injury;
- any Sickness or Mental or Nervous Disorders as defined in this certificate;
- commission of a felony while operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member as a professional of any aircraft or hot air balloon as a professional, including those which are not motor-driven, unless flying as a fare paying passenger;
- practicing for or participating in any professional competitive athletic contests for which any type of compensation or remuneration is received.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusion. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Claim Procedures** provision in the **Claims Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days.

The **Appeal Procedures** provision in the **Claim Provisions** section of the certificate is amended to reflect that the appeals specialist is a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate or the supervisor of the person making the initial determination.

The **Assignment** provision in the **General Provisions** section of the certificate is amended to reflect that in no event may an Insured's assignee be a healthcare provider.

The **Contestability** provision in the **General Provisions** section of the certificate is amended to remove reference to Fraud. Language has been replaced to read as follows:

However, in the event of nonpayment of an Insured's premium, we can take action at any time under the provision titled Cancellation or Modification to the Policy and this Certificate of Coverage and as permitted by applicable law.

The **Injury** definition in the **Glossary** section of the certificate is amended to read "Any damage or harm to the body.

The **Nurse** definition in the **Glossary** section of the certificate is amended to define a Nurse to include an Advanced Practice Registered Nurse, graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

The **Physician** definition in the **Glossary** section of the certificate is amended as follows:

A person who:
- is a licensed health care provider practicing within the scope of their medical license; and
- provides medical care and treatment services according to the laws and regulations of the governing jurisdiction, including Advanced Practice Registered Nurses and Physician's Assistants.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

The **Telemedicine** definition in the **Glossary** section of the certificate is amended as follows:

The use of audio, video, or other electronic media communications for the purpose of the Insured's diagnosis, consultation or treatment. This does not include the use of facsimile.

**For residents of Ohio**

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

**Newborn Coverage Feature**
Your newborn, newly adopted, or Children placed for adoption will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid immediately or within 30 days after receipt of satisfactory Written Proof of Loss.

The **Children** definition in the **Glossary** section of the certificate for "your lawfully adopted child as of the earliest of the date" is amended as follows:

- your lawfully adopted child as of the earliest of the date;
- the child is placed in your home or in a medical facility;
- you have initiated adoption proceedings;
- a petition is filed for you to adopt the child; or
- an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child.

**For residents of South Dakota**

The **Exclusions** provision in the **Accident Details** section of the certificate for "operating any motorized vehicle while intoxicated" is replaced with the following:

- commission of a felony while operating any motorized vehicle while intoxicated.

The **Exclusions** provision in the **Accident Details** section of the certificate for Accidental Death and Dismemberment Benefits is amended so that any exclusions for claims caused by, contributed to by, or resulting from any of the following:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

are removed.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

The **Physician** definition in the **Glossary** section of the certificate is amended as follows:

A person performing tasks that are within the limits of their medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Family Member, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us. This exclusion does not apply in those areas in which the above mentioned person is the only Physician in the area and acting within the scope of their normal employment.

**For residents of Texas**

The **Recovery Care Benefits** in the **Accident Highlights** section of the certificate has been amended to add Acquired Brain Injury, Telehealth Service, and Telemedicine Medical Service.

An **Acquired Brain Injury** benefit has been added to the **Recovery Care Benefits** category in the **Accident Details** section of the certificate as follows:

**Acquired Brain Injury**
Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured requires services, therapies, or treatment as a result of an Acquired Brain Injury sustained in a Covered Accident.

For purposes of this benefit, the following are considered services, therapies, and treatment for an Acquired Brain Injury:
- Cognitive Communication Therapy;
- Cognitive Rehabilitation Therapy;
- Community Reintegration Services;
- Neurobehavioral;
- Neurocognitive Therapy and Rehabilitation;
- Neurofeedback Therapy;
- Neurophysiological;
- Neuropsychological;
- Post-acute Transition Services;
- Psychophysiological Testing or Treatment; and
- Remediation.

A Physician must prescribe the services, therapies, or treatment, and they must be performed at a Physician's office or at a Hospital on an inpatient or Outpatient Basis.

*Benefit Duration*
This benefit is payable up to a maximum of six services, therapies, or treatment per Insured per Covered Accident.

A **Telehealth** benefit has been added to the **Recovery Care Benefits** category in the Accident Details section of the certificate as follows:

**Telehealth Service**
Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured receives the Telehealth Service as a result of a Covered Accident.

The Telehealth Service must be provided within 60 days of the Covered Accident.

For purposes of this benefit, routine examinations or preventive testing do not meet the Benefit Description of Telehealth Service.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

A **Telemedicine Medical Service** benefit has been added to the **Recovery Care Benefits** category in the Accident Details section of the certificate as follows:

**Telemedicine Medical Service**
Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured receives the Telemedicine Medical Service as a result of a Covered Accident.

The Telemedicine Medical Service must be provided within 60 days of the Covered Accident.

For purposes of this benefit, routine examinations or preventive testing do not meet the Benefit Description of Telemedicine Medical Service.

*Benefit Duration*
This benefit is payable once per Insured per Covered Accident.

The **Fraud** provision in the **General Provisions** section of the certificate is amended as follows:

We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended as follows:

**Payment of Benefits**
Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits. Benefits for Children who are receiving financial and medical benefits through the Texas Department of Human Services will be paid to the Texas Department of Human Services whenever:

- the Texas Department of Human Services is paying benefits pursuant to Chapters 31 and 32 of the Human Resources Code, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code;
- the parent who is covered by this certificate has possession or access to the Child pursuant to a court order, or is not entitled to access or possession of the Child and is required by the court to pay child support; and
- we are notified at the time of claim that the Child is receiving financial and medical assistance.

In addition, benefits for Children may also be paid to a possessory or managing conservator of the Child if the appointment for that Child was issued by a court in this or another state.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision or, if required, to the Texas Department of Human Services.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Glossary** section of the certificate has been amended to include the following definitions:

**Cognitive Communication Therapy**
Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

**Cognitive Rehabilitation Therapy**
Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

**Community Reintegration Services**

Services that facilitate the continuum of care as an affected individual transitions into the community.

**Neurobehavioral Testing**
An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

**Neurobehavioral Treatment**
Interventions that focus on behavior and the variables that control behavior.

**Neurocognitive Rehabilitation**
Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

**Neurocognitive Therapy**
Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

**Neurofeedback Therapy**
Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

**Neurophysiological Testing**
An evaluation of the functions of the nervous system.

**Neurophysiological Treatment**
Interventions that focus on the functions of the nervous system.

**Neuropsychological Testing**
The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

**Neuropsychological Treatment**
Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

**Post-acute Transition Services**
Services that facilitate the continuum of care beyond the initial neurological consult through rehabilitation and community reintegration.

**Psychophysiological Testing**
An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

**Psychophysiological Treatment**
Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

**Remediation**
The process(es) of restoring and improving a specific function.

**Telehealth Services**
A health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- compressed digital interactive video, audio, or data transmission;
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

**Telemedicine Medical Service**
A health care service initiated by a Physician or provided by a health professional acting under Physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- compressed digital interactive video, audio, or data transmission;
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

## For residents of Utah

The **Burns** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Burn within 90 days of the Covered Accident or as soon as reasonably possible.

The **Concussion** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Concussion within 14 days of the Covered Accident or as soon as reasonably possible.

The **Connective Tissue Damage** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Connective Tissue Damage within 90 days of the Covered Accident or as soon as reasonably possible.

The **Dislocations** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to set the dislocated joint within 90 days of the Covered Accident or as soon as reasonably possible.

The **Eye Injury** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to remove the object within 90 days of the Covered Accident or as soon as reasonably possible.

The **Fractures** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to confirm the bone fracture within 90 days of the Covered Accident by X-ray or other medical imaging study or as soon as reasonably possible.

The **Internal Injuries** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Internal Injury within 90 days of the Covered Accident or as soon as reasonably possible and to remove "internal bleeding" from the description criteria of Internal Injuries.

The **Knee Cartilage (Meniscus) Injury** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to confirm the Knee Cartilage (Meniscus) Injury within 90 days or as soon as reasonably possible of the Covered Accident by an MRI, other medical imaging study, or Surgical Procedure.

The **Lacerations** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to treat the Laceration within three days of the Covered Accident or as soon as reasonably possible.

The **Loss of a Digit** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to treat the Loss of a Digit within 90 days of the Covered Accident or as soon as reasonably possible.

The **Ruptured or Herniated Disc** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Ruptured or Herniated Disc within 90 days of the Covered Accident or as soon as reasonably possible.

The **Ambulance** benefit in the **Accident Details** section of the certificate has been amended to allow the Ambulance transportation within 180 days of the Covered Accident or as soon as reasonably possible.

The **Emergency Department** benefit in the **Accident Details** section of the certificate has been amended to allow the Emergency Department treatment within three days of the Covered Accident or as soon as reasonably possible.

The **Injections to Prevent or Limit Infection** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to administer the injection within 180 days of the Covered Accident or as soon as reasonably possible.

The **Medical Imaging** benefit in the **Accident Details** section of the certificate has been amended to allow Medical Imaging to happen within 180 days of the Covered Accident or as soon as reasonably possible.

The **Pain Management Injections** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to administer the injection within 180 days of the Covered Accident or as soon as reasonably possible.

The **Skin Grafts** benefit in the **Accident Details** section of the certificate has been amended to allow the Insured to receive the Skin Graft within 180 days of the Covered Accident or as soon as reasonably possible.

The **Transfusions** benefit in the **Accident Details** section of the certificate has been amended to allow the Insured to receive the Transfusion within 180 days of the Covered Accident or as soon as reasonably possible.

The **Transportation** benefit in the **Accident Details** section of the certificate has been amended to allow the Transportation within 180 days of the Covered Accident or as soon as reasonably possible.

The **Treatment in a Physician's Office or Urgent Care Facility** benefit in the **Accident Details** section of the certificate has been amended to allow for treatment within 14 days of the Covered Accident or as soon as reasonably possible.

The **Admission** benefit in the **Accident Details** section of the certificate has been amended to allow the Admission and Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Daily Stay** benefit in the **Accident Details** section of the certificate has been amended to allow the Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Short Stay** benefit in the **Accident Details** section of the certificate has been amended to allow the Short Stay within 180 days of the Covered Accident or as soon as reasonably possible.

The **Coma** benefit in the **Accident Details** section of the certificate has been amended to define a Coma as a continuous state of profound unconsciousness characterized by the absence of eye opening, verbal response, and motor response.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by or resulting from commission of or attempt to commit a felony; engaging in an illegal occupation or activity; or participation in a riot, insurrection, or terrorist activity is applied only if you were a voluntary participant.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any exclusion for claims caused by or resulting from "operating any motorized vehicle while intoxicated" reads as follows:

- operating any motorized vehicle while intoxicated in violation of a law. For purposes of this exclusion, "intoxicated" means the Insured's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any Accidental Death and Dismemberment Benefit claims caused by or resulting from "being intoxicated" reads as follows:

- being intoxicated at the time of the incident while operating a vehicle or other device involved in the incident in violation of a law. For purposes of this exclusion, "intoxicated" means the Insured's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred; and

The **Children** definition in the **Glossary** section of the certificate is amended as follows:

Any child from the moment of birth to age 26 who is:
- your own natural offspring;
- your Spouse's child;

- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility. If placement for adoption occurs within 30 days of the child's birth, coverage begins from the moment of birth. If placement for adoption occurs 30 days or more after the child's birth, coverage begins from the date of placement;
  - you have initiated adoption proceedings;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; or
- any other child for whom you are required by court or administrative order to provide coverage for.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

The **Hospital** definition in the **Glossary** section of the certificate has been amended as follows:

An institution licensed as a hospital and operating within the scope of its license and provides medically necessary hospital confinement or treatment for sick or injured people.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation or Subacute Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Nurse** definition in the **Glossary** section of the certificate has been amended to be defined as a healthcare professional trained, duly licensed, and operating within the scope of their license, to care for people with Injuries or Sicknesses.

The **Physician** definition in the **Glossary** section of the certificate has been amended to be defined as a person performing tasks that are within the limits of their medical license.

**For residents of Vermont**

The state of **Vermont** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Vermont law. The minimum requirements of Vermont law will apply to your claim.

The minimum hours requirement of the **Eligible Groups** provision in the **Accident Highlights** section of the certificate is amended to cover eligible employees working at least 17.5 hours per week.

The **Emergency Dental Repair** benefit in the **Accident Details** section of the certificate has been amended to allow an Emergency Dental Repair to be made within 365 days of the Covered Accident.

The **Injections to Prevent or Limit Infection** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to administer the injection within 365 days of the Covered Accident.

The **Medical Imaging** benefit in the **Accident Details** section of the certificate has been amended to allow Medical Imaging to happen within 365 days of the Covered Accident.

The **Pain Management Injections** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to administer the injection within 365 days of the Covered Accident.

The **Skin Grafts** benefit in the **Accident Details** section of the certificate has been amended to allow the Insured to receive the Skin Graft within 365 days of the Covered Accident.

The **Transfusions** benefit in the **Accident Details** section of the certificate has been amended to allow the Insured to receive the Transfusion within 365 days of the Covered Accident.

The **Treatment in a Physician's Office or Urgent Care Facility** benefit in the **Accident Details** section of the certificate has been amended to allow for treatment within 365 days of the Covered Accident.

The **Rehabilitation or Subacute Rehabilitation Unit** benefit in the **Accident Details** section of the certificate has been amended to allow for a benefit payable up to a maximum of 30 days per Insured per Covered Accident.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from any Sickness, bodily infirmity, or other abnormal physical condition, including diagnosis, treatment, or surgery for it is amended to exclude Mental or Nervous Disorders.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any Accidental Death and Dismemberment Benefit claims caused by, contributed to by, or resulting from:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

are removed.

The **Autopsy** provision in the **Claim Provisions** section of the certificate is amended so that when we request an Autopsy where it is allowed by law, and not prohibited by the Insured's religion, it will be at our expense.

The **Fraud** provision in the **General Provisions** section of the certificate is amended as follows:

> We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.
>
> Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.
>
> These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

The **Covered Accident** definition in the **Glossary** section of the certificate is amended as follows:

A bodily Injury sustained by an Insured, which is the direct cause of the loss, independent of disease or bodily infirmity and which:

- occurs on or after the Coverage Effective Date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

The **Hospital** definition in the **Glossary** section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Hospital:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Mental or Nervous Disorders** definition in the **Glossary** section of the certificate is removed in its entirety.

The **Rehabilitation Unit** definition in the **Glossary** section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Rehabilitation Unit:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Subacute Rehabilitation Unit** definition in the Glossary section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Subacute Rehabilitation Unit:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Substance Abuse** definition in the **Glossary** section of the certificate is removed in its entirety.

## ERISA

### Additional Summary Plan Description Information

If the Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the summary plan description. The summary plan description and the Policy constitute the Plan. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information contained in this document.

**Name of Plan:**
Forest River, Inc. Plan

**Name and Address of Employer:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514

**Plan Identification Number:**
a. Employer IRS Identification #: 20-3284366
b. Plan #: 0

**Type of Welfare Plan:**
Accident

**Type of Administration:**
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

**ERISA Plan Year Ends:**
December 31

**Plan Administrator, Name, Address, and Telephone Number:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514
(534) 389-4600

Forest River, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

**Agent for Service of Legal Process on the Plan:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Insurance Company, 2211 Congress Street, Portland, Maine 04122, under 984567 012. Contributions to the Plan are made as stated under Paying for Coverage in the Certificate of Coverage.

**Employer's Right to Amend the Plan**
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying

policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in Writing and endorsed on or attached to the Plan.

**Employer's Right to Request Policy Change**

The Employer can request a Policy change. A change to the Policy will be made valid once approved by one of our officers. The change must be in Writing and endorsed on or attached to the Policy.

**Cancellation of the Policy by the Employer**

The Employer may cancel the Policy by providing us Written notice. In any event of cancellation, coverage will continue through the end of the day the cancellation takes effect.

A cancellation of the Policy will not affect a Payable Claim.

**Cancellation or Modification of the Policy by Us**

In addition, we may cancel or modify the Policy if the Policy terms are not met, the Employer fails to satisfy its obligations, premium is not paid, a change in the Employer or in the law impacts the benefits payable or the risks insured or, depending on the Policy, at our election after any rate guarantee period.

In any event, we will provide Written notice to the Employer prior to any cancellation or modification date. The Employer may cancel the Policy if it chooses not to accept the Policy modifications made by us.

A cancellation of the Policy will not affect a Payable Claim.

**Your Rights Under ERISA**

As a participant in the 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 the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon Written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps 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 pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's 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, if, for example, it finds your claim is frivolous.

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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

# Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

**COLLECTING INFORMATION**
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

**SHARING INFORMATION**
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

**SAFEGUARDING INFORMATION**
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

**ACCESS TO INFORMATION**
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

**CORRECTION OF INFORMATION**
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

**COVERAGE DECISIONS**
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

**CONTACTING US**
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

2020 Unum Group. All rights reserved. Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

unum.com MK-1883 (06-2020)

# NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

## Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

### Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

### Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

### Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

**The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**

**Forest River, Inc.**

# Your Critical Illness Plan

Policy No. 984568 011

Underwritten by Unum Insurance Company

10/21/2025

**Unum Insurance Company**
2211 Congress Street
Portland, ME 04122
(877) 225-2712
services.unum.com

## Group Critical Illness Insurance Certificate of Coverage

**Policyholder:** Forest River, Inc.

**Policy Number:** 984568 011

**Policy Effective Date:** November 1, 2025

**Policy Anniversary:** January 1

**Governing Jurisdiction:** Indiana

This Certificate of Coverage (the "certificate") is issued to you under the policy which is a contract between us and the Policyholder. If the provisions of this certificate conflict with the provisions of the policy, the provisions of the policy will govern. The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the laws of other states and the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

**This certificate provides benefits under a non-participating policy. The limited benefits provided under this certificate are a supplement to major medical coverage and are not a substitute for major medical coverage or other minimal essential coverage as required by federal law.**

**This certificate contains proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an Insured from receiving benefits under this certificate. Please read your certificate carefully and keep it in a safe place.**

All references to defined terms, provision titles, and section headings have been capitalized.

If you have any questions about provisions of this certificate, please contact your Employer, or you may contact us at (877) 225-2712 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

## Consumer Complaint Notice

**If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.**

## Table of Contents


**Critical Illness Highlights** ..... **4**

Eligible Group(s) ..... 4

Paying for Coverage ..... 4

Coverage Amount ..... 4

Benefit Amount ..... 4

Certificate Riders ..... 4

Covered Conditions ..... 4

**Critical Illness Details** ..... **6**

Covered Condition Benefit ..... 6

Reoccurring Condition Benefit ..... 6

Covered Conditions ..... 6

Critical Illnesses ..... 6

Cancer ..... 8

Supplemental Critical Illnesses ..... 10

Progressive Diseases ..... 14

Additional Benefits ..... 15

Additional Critical Illnesses for your Children ..... 17

**Critical Illness Details | Exclusions and Limitations** ..... **19**

**Continuity of Coverage** ..... **20**

**Start of Coverage** ..... **22**

**End of Coverage** ..... **24**

**Claim Provisions** ..... **26**

**General Provisions** ..... **29**

**Glossary** ..... **31**

**State Requirements** ..... **37**

Critical Illness Insurance provides financial protection for an Insured by paying a lump-sum benefit if the Insured is diagnosed with a Covered Condition payable under this certificate.

This section includes highlights of an Insured's coverage. Please refer to the **Critical Illness Details** for further information on the benefits available.

**Eligible Group(s)**

All Full Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

**Paying for Coverage**

*For you*
*Contributory Coverage*
You must make premium contributions for your coverage.

*For your Spouse*
*Contributory Coverage*
You must make premium contributions for your Spouse's coverage.

*For your Children*
Coverage for your Children is automatically included in the cost of your coverage.

**Coverage Amount**

The following Coverage Amounts are available to you. If you choose to apply and become insured for coverage, your Children will automatically be enrolled for coverage. You will also have the opportunity to apply for coverage for your Spouse.

| For You | For your Spouse | For your Children |
|---|---|---|
| A minimum of $5,000 to a maximum of $30,000, in $5,000 increments | 100% of your Coverage Amount | 100% of your Coverage Amount |

**Benefit Amount**

The Benefit Amount is the amount an Insured may receive for a Payable Claim. The Benefit Amount is calculated using the Insured's Coverage Amount multiplied by the Percentage of Coverage Amount for the Covered Condition, subject to all other terms and provisions of this certificate.

The Percentage of Coverage Amount payable for each Covered Condition is listed in the Critical Illness Details section.

Any dollar amount listed under the Percentage of Coverage Amount will be the Benefit Amount payable for that Covered Condition.

**Certificate Riders**

The following riders are attached to this certificate:

Be Well Benefit
Portability of Critical Illness Insurance

**Covered Conditions**

**Covered Conditions for you, your Spouse, and Children:**

**Critical Illnesses**

| | |
|---|---|
| Coronary Artery Disease (Major) | Major Organ Failure Requiring Transplant |
| Coronary Artery Disease (Minor) | Stroke |
| End Stage Renal (Kidney) Failure | Sudden Cardiac Arrest |
| Heart Attack (Myocardial Infarction) | |

**Cancer**

| | |
|---|---|
| Invasive Cancer (including all Breast Cancer) | Skin Cancer |
| Non-Invasive Cancer | |

**Supplemental Critical Illnesses**

| | |
|---|---|
| Benign Brain Tumor | Loss of Speech |
| Bone Marrow or Stem Cell Transplant | Occupational Human Immunodeficiency Virus (HIV) or Hepatitis |
| Coma | Occupational Post-Traumatic Stress Disorder (PTSD) |
| Infectious Disease | Permanent Paralysis |
| Loss of Hearing | Pulmonary Embolism |
| Loss of Sight | Transient Ischemic Attack (TIA) |

**Progressive Diseases**

| | |
|---|---|
| Addison's Disease | Multiple Sclerosis (MS) |
| Amyotrophic Lateral Sclerosis (ALS) | Muscular Dystrophy |
| Dementia (including Alzheimer's Disease) | Myasthenia Gravis |
| Huntington's Disease | Parkinson's Disease |
| Lupus | Systemic Sclerosis (Scleroderma) |

**Additional Benefits**

| | |
|---|---|
| Building Benefit | Cancer Treatment and Care |

**Covered Conditions for your Children:**

**Additional Critical Illnesses for your Children**

| | |
|---|---|
| Cerebral Palsy | Down Syndrome |
| Cleft Lip or Palate | Sickle Cell Anemia |
| Congenital Heart Disease | Spina Bifida |
| Cystic Fibrosis | Type 1 Diabetes |

The information in this section provides details about the benefits that may be payable, any applicable Exclusions and Other Features included in an Insured's coverage.

Benefits will only be payable for an Insured's Covered Conditions that have a Date of Diagnosis on or after the Insured's Coverage Effective Date.

**Covered Condition Benefit**

The Covered Condition Benefit is payable once per Covered Condition per Insured.

We will pay a Covered Condition Benefit for a different Covered Condition if:
- the new Covered Condition is medically unrelated to the first Covered Condition; or
- the Date of Diagnoses are separated by more than 180 days.

If an Insured's diagnosis satisfies the Condition Definition and Date of Diagnosis requirements for more than one Covered Condition, we will pay the Covered Condition with the highest Percentage of Coverage Amount.

**Reoccurring Condition Benefit**

We will pay the Reoccurring Condition Benefit for the diagnosis of the same Covered Condition if the Covered Condition Benefit was previously paid and the new Date of Diagnosis is more than 30 days after the prior Date of Diagnosis.

The Benefit Amount for any Reoccurring Condition Benefit is 100% of the Percentage of Coverage Amount for that Covered Condition.

The following Covered Conditions are eligible for a Reoccurring Condition Benefit:

| | |
|---|---|
| Benign Brain Tumor | Invasive Cancer (including all Breast Cancer) |
| Bone Marrow or Stem Cell Transplant | Major Organ Failure Requiring Transplant |
| Coma | Non-Invasive Cancer |
| Coronary Artery Disease (Major) | Occupational Post-Traumatic Stress Disorder (PTSD) |
| Coronary Artery Disease (Minor) | Pulmonary Embolism |
| End Stage Renal (Kidney) Failure | Stroke |
| Heart Attack (Myocardial Infarction) | Sudden Cardiac Arrest |
| Infectious Disease | Transient Ischemic Attack (TIA) |

## Covered Conditions

| Critical Illnesses | | Percentage of Coverage Amount |
|---|---|---|
| **Coronary Artery Disease (Major)** | *Condition Definition*<br>A narrowing or blockage of one or more coronary arteries resulting from plaque buildup.<br><br>*Date of Diagnosis*<br>The date a Physician recommends the Insured undergo a Surgical Procedure for an Abdominal Aortic Aneurysm, Coronary Artery Bypass Graft, or valve replacement. | **50%** |
| **Coronary Artery Disease (Minor)** | *Condition Definition*<br>A narrowing or blockage of one or more coronary arteries resulting from plaque buildup.<br><br>*Date of Diagnosis*<br>The date a Physician recommends the Insured undergo one of the following procedures:<br>- a catheterization procedure of balloon angioplasty; | **10%** |

- stent placement;
- atherectomy;
- automatic implantable (or internal) cardioverter defibrillator (AICD);
- laser angioplasty;
- pacemaker placement;
- thrombectomy.

**End Stage Renal (Kidney) Failure** — **100%**

*Condition Definition*
A chronic irreversible failure of the function of both kidneys.

*Date of Diagnosis*
The earliest date:
- a Physician recommends regular hemodialysis or peritoneal dialysis to sustain life;
- the Insured has a kidney transplant performed; or
- the Insured is placed on the UNOS (United Network for Organ Sharing) list for a kidney transplant.

**Heart Attack (Myocardial Infarction)** — **100%**

*Condition Definition*
The death of a portion of heart muscle (myocardium) as a result of obstruction of one or more of the coronary arteries. A positive diagnosis of a heart attack must occur and must be supported by two or more of the following:
- chest pain;
- electrocardiographic (EKG) changes indicative of a heart attack;
- elevation of biochemical markers of myocardial necrosis; or
- confirmatory imaging studies.

For purposes of this benefit, the following do not meet the Condition Definition of Heart Attack:
- an established (old) heart attack;
- angina;
- atherosclerotic heart disease;
- cardiac arrest (including arrhythmias);
- congestive heart failure;
- Coronary Artery Disease; and
- any other disease, Injury, or dysfunction of the cardiovascular system.

If a heart attack results in death, an autopsy confirmation or death certificate verifying the heart attack as the cause of death will be accepted.

*Date of Diagnosis*
The date the death of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack Condition Definition.

**Major Organ Failure Requiring Transplant** — **100%**

*Condition Definition*
Failure of the heart, liver, both lungs, or pancreas resulting in the Insured being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

If an Insured is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid.

*Date of Diagnosis*
The date the Insured is placed on the UNOS list for organ transplant(s).

**Stroke** — **100%**

*Condition Definition*

The sudden death of brain cells due to lack of oxygen, caused by blockage of blood flow or rupture of an artery to the brain.

For purposes of this benefit, the following do not meet the Condition Definition of Stroke:
- Transient Ischemic Attack;
- brain injury associated with hypoxia, anoxia, or hypotension;
- brain injury related to trauma or infection;
- ischemic disorders of the vestibular system; and
- vascular disease affecting the eye or optic nerve.

If a stroke results in death, an autopsy confirmation or death certificate verifying the stroke as the cause of death will be accepted.

*Date of Diagnosis*
The date a Stroke occurs and the diagnosis must be supported by:
- neurological deficits persisting for at least 30 days after the Stroke including but not limited to impaired motor function, altered sensation, vision loss, difficulty swallowing, or Cognitive Impairment confirmed by a Physician; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

| | | |
|---|---|---|
| **Sudden Cardiac Arrest** | *Condition Definition*<br>The sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, cardiomyopathy, or hypertension.<br><br>For purposes of this benefit, a Heart Attack (Myocardial Infarction) does not meet the Condition Definition of Sudden Cardiac Arrest.<br><br>*Date of Diagnosis*<br>The date the pumping action of the heart fails based on the Sudden Cardiac Arrest Condition Definition. | **100%** |

| **Cancer** | | **Percentage of Coverage Amount** |
|---|---|---|
| **Invasive Cancer (Including all Breast Cancer)** | *Condition Definition*<br>A disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.<br><br>Any cancer of the breast is considered Invasive Cancer including breast cancer which is classified as Stage 0 or In Situ.<br><br>For purposes of this benefit, the following do not meet the Condition Definition of Invasive Cancer:<br>- pre-malignant conditions or conditions with malignant potential;<br>- cancer that has not yet become invasive, typically classified as Stage 0 or In Situ; and<br>- cancer on the surface of the body (skin) that may be:<br>  - melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;<br>  - basal cell carcinoma; or<br>  - squamous cell carcinoma of the skin. | **100%** |

*Date of Diagnosis*
The date the tissue specimen, blood samples or titer(s) are taken on which the Pathological Diagnosis of Invasive Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Any subsequent Date of Diagnosis for Invasive Cancer must follow a period of at least 180 days where the Insured has had no evidence of disease or treatment for cancer. Evidence of disease or treatment does not include preventive medications or routine scheduled follow-up visits to a Physician.

If the Insured is diagnosed with Non-Invasive Cancer after the Coverage Effective Date and receives a benefit, and that cancer spreads and meets the Condition Definition for Invasive Cancer, we will pay the difference in Percentage of Coverage Amount.

**Non-Invasive Cancer** — **50%**

*Condition Definition*
A malignant tumor which is typically classified as Stage 0 or In Situ, that has not yet become invasive but is confined to the site of origin without having invaded neighboring tissue.

For purposes of this benefit, the following do not meet the Condition Definition of Non-Invasive Cancer:
- pre-malignant conditions or conditions with malignant potential;
- any Stage 0 or In Situ cancer of the breast; and
- cancer on the surface of the body (skin) that may be:
  - melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;
  - basal cell carcinoma; or
  - squamous cell carcinoma of the skin.

*Date of Diagnosis*
The date the tissue specimen, blood samples or titer(s) are taken on which the Pathological Diagnosis of Non-Invasive Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Any subsequent Date of Diagnosis for Non-Invasive Cancer must follow a period of at least 180 days where the Insured has had no evidence of disease or treatment for cancer. Evidence of disease or treatment does not include preventive medications or routine scheduled follow-up visits to a Physician.

**Skin Cancer** — **$1,000**

*Condition Definition*
Cancer on the surface of the body (skin) that may be:
- melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;
- basal cell carcinoma; or
- squamous cell carcinoma of the skin.

*Date of Diagnosis*
The date the tissue specimen is taken on which the Pathological Diagnosis of Skin Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

| **Supplemental Critical Illnesses** | | **Percentage of Coverage Amount** |
|---|---|---|
| **Benign Brain Tumor** | *Condition Definition*<br>A non-cancerous brain tumor resulting in neurological deficits including but not limited to loss of sight, loss of hearing, or balance disruption.<br><br>For purposes of this benefit, the following do not meet the Condition Definition of Benign Brain Tumor:<br>- tumors of the skull;<br>- pituitary adenomas; and<br>- germinomas.<br><br>We will not pay this benefit if an Insured is diagnosed with any of the following conditions prior to their Coverage Effective Date:<br>- Neurofibromatosis I;<br>- Neurofibromatosis II;<br>- Von Hippel Lindau;<br>- Tuberous Sclerosis;<br>- Li-Fraumeni Syndrome;<br>- Cowden Disease; and<br>- Turcot Syndrome.<br><br>*Date of Diagnosis*<br>The date of the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination. | **100%** |
| **Bone Marrow or Stem Cell Transplant** | *Condition Definition*<br>A surgical transplant of bone marrow or peripheral stem cell for the treatment of invasive cancer.<br><br>*Date of Diagnosis*<br>The date the Insured undergoes the actual surgery for a bone marrow or stem cell transplant or the date the Insured is diagnosed by a Physician as requiring the recommended transplant.<br><br>We will pay this benefit only if there is medical evidence to support the diagnosis, and the Insured is too ill to undergo the recommended transplant.<br><br>This benefit is payable once per Insured. | **25%** |
| **Coma** | *Condition Definition*<br>A continuous state of profound unconsciousness requiring intubation for respiratory assistance lasting for a period of 7 or more consecutive days, characterized by the absence of:<br>- eye opening;<br>- verbal response; and<br>- motor response.<br><br>For purposes of this benefit, the following do not meet the Condition Definition of Coma:<br>- Coma due to Stroke; and<br>- any medically induced Coma.<br><br>*Date of Diagnosis*<br>The date a Physician confirms a Coma. | **100%** |
| **Infectious** | *Condition Definition* | **25%** |

| | | |
|---|---|---|
| **Disease** | A severe infectious or contagious disease diagnosed by a Physician that results in an Insured being Confined to a Hospital for 5 or more consecutive days. Infectious or contagious diseases may include, but are not limited to:<br>- Rabies;<br>- Meningitis;<br>- Lyme Disease;<br>- Antibiotic resistant bacteria (including MRSA);<br>- Sepsis;<br>- Tuberculosis;<br>- Diphtheria;<br>- Encephalitis;<br>- Legionnaire's disease;<br>- Malaria;<br>- Necrotizing fasciitis (flesh eating bacteria);<br>- Osteomyelitis;<br>- Tetanus;<br>- COVID-19.<br><br>*Date of Diagnosis*<br>The date a Physician confirms the diagnosis of an Infectious Disease. | |
| **Loss of Hearing** | *Condition Definition*<br>Total and irrecoverable Loss of Hearing in both ears that follows a period where an Insured had the ability to hear.<br><br>For purposes of this benefit, the following do not meet the Condition Definition of Loss of Hearing:<br>- congenital birth defects;<br>- developmental delays; and<br>- any Loss of Hearing that can be corrected by any procedure, aid, or device.<br><br>*Date of Diagnosis*<br>The date a Physician confirms Loss of Hearing in both ears. | **100%** |
| **Loss of Sight** | *Condition Definition*<br>Permanent reduction in sight certified by a Physician that follows a period where an Insured was not legally blind such that:<br>- sight in the better eye reduced to a best corrected visual acuity of 20/200 or less (Snellen or E-Chart Acuity); or<br>- visual field remaining is less than 20° in the better eye.<br><br>For purposes of this benefit, the following do not meet the Condition Definition of Loss of Sight:<br>- congenital birth defects;<br>- developmental delays; and<br>- any loss of sight that can be corrected by any procedure, aid, or device.<br><br>*Date of Diagnosis*<br>The date a Physician confirms Loss of Sight. | **100%** |
| **Loss of Speech** | *Condition Definition*<br>Total and irrecoverable Loss of Speech that follows a period where an Insured had the ability to speak.<br><br>For purposes of this benefit, the following do not meet the Condition Definition of Loss of Speech:<br>- congenital birth defects; | **100%** |

- developmental delays; and
- any loss of speech that can be corrected by any procedure, aid, or device.

*Date of Diagnosis*
The date a Physician confirms Loss of Speech.

**Occupational Human Immunodeficiency Virus (HIV) or Hepatitis** — **100%**

*Condition Definition*
An infection resulting from exposure to HIV or Hepatitis B, C, or D contaminated fluids as the result of a Covered Accident during the normal course of duties for an occupation in which an Insured is regularly engaged and for which compensation is earned.

For purposes of this benefit, the following do not meet the Condition Definition of Occupational HIV or Hepatitis:
- exposure or infection as the result of IV drug use;
- exposure or infection as the result of sexual transmission; and
- exposure or infection determined that is not the result of an occupational Covered Accident.

*Date of Diagnosis*
The date a state certified and licensed laboratory receives a positive confirmatory antibody test for HIV or Hepatitis B, C, or D provided the following actions have been taken:
- within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards, or guidelines that apply to the Insured's occupation or profession;
- the Covered Accident is investigated by the employer and we receive a copy of the Written investigation report;
- an initial confirmatory antibody test is taken within five days of the Covered Accident and is negative for the presence of HIV or Hepatitis B, C, or D; and
- a follow-up confirmatory antibody test is taken between 90 and 180 days from the date of the initial confirmatory antibody test and is positive for HIV or Hepatitis B, C, or D.

**Occupational Post-Traumatic Stress Disorder (PTSD)** — **100%**

*Condition Definition*
A Mental or Nervous Disorder that is the direct result of a Traumatic Occupational Event characterized by persistent mental and emotional stress resulting in the following that persist for at least 30 days following the date of the Traumatic Occupational Event:
- recurrent, involuntary, and intrusive memories of the Traumatic Occupational Event;
- recurrent distressing dreams, dissociative reactions, or flashbacks related to the Traumatic Occupational Event;
- psychological distress or physiological reactions to cues that resemble or remind an Insured of the Traumatic Occupational Event;
- behaviors of avoidance of stimuli or external reminders associated with the Traumatic Occupational Event;
- negative alterations in cognition, mood, or behavior that begin or worsen after the Traumatic Occupational Event; and
- impairments in social, occupational, and other areas of daily functioning.

For purposes of this benefit, the following do not meet the Condition Definition of Occupational PTSD if the:
- condition is the result of reactivation of symptoms from a Traumatic Occupational Event that occurred prior to the Insured's Coverage Effective Date;

- PTSD is the result of any non-occupational event or the event took place outside of the normal course of an Insured's occupational duties for their Employer;
- condition is better explained as bereavement;
- condition meets the criteria of another Mental or Nervous Disorder; or
- symptoms are due to the direct physiological effects of Substance Abuse.

*Date of Diagnosis*
The date a Physician diagnoses the Occupational PTSD. The diagnosis must be supported by the following in accordance with the criteria described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM):
- medical evidence;
- psychiatric assessment; or
- psychological screening.

**Permanent Paralysis** — **100%**

*Condition Definition*
The complete and permanent loss of the use of two or more limbs due to a new paralysis for a continuous period of at least 90 days.

For a severed spinal cord with supporting clinical and radiological evidence and no expectation of return of function, the continuous 90 day requirement will be waived.

For purposes of this benefit, losing the use of two or more limbs as the result of a Stroke does not meet the Condition Definition of Permanent Paralysis.

*Date of Diagnosis*
The date a Physician diagnoses the paralysis or severed spinal cord.

**Pulmonary Embolism** — **25%**

*Condition Definition*
A sudden blockage in a pulmonary artery or a branch of a pulmonary artery due to a blood clot as confirmed by a pulmonary angiogram, ventilation perfusion scan, computerized tomography scan, magnetic resonance imaging, or other reliable imaging techniques.

*Date of Diagnosis*
The date a Physician confirms the diagnosis based on the criteria listed under the Pulmonary Embolism Condition Definition.

**Transient Ischemic Attack (TIA)** — **25%**

*Condition Definition*
A temporary ischemic event (including prolonged reversible ischemic attacks) in which:
- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery; and
- there is no evidence of cerebral tissue damage on diagnostic imaging.

*Date of Diagnosis*
The date a Physician confirms the diagnosis based on documented neurological deficits, neuroimaging studies, and reversible functional neurological impairments.

If an Insured is diagnosed with a Stroke within 90 days of a covered Transient Ischemic Attack (TIA), we will pay the difference in

Percentage of Coverage Amount between these two benefits.

| **Progressive Diseases** | | **Percentage of Coverage Amount** |
|---|---|---|
| **Addison's Disease** | *Condition Definition*<br>A long-term endocrine or hormonal disorder that occurs when the adrenal glands do not produce sufficient amounts of certain hormones, including cortisol.<br><br>For purposes of this benefit, adrenal insufficiency resulting from prolonged corticosteroid treatment does not meet the Condition Definition of Addison's Disease.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two of more Activities of Daily Living or becomes Totally Disabled for 90 days due to Addison's Disease as diagnosed by a Physician. | **25%** |
| **Amyotrophic Lateral Sclerosis (ALS)** | *Condition Definition*<br>A nervous system disease that causes muscle weakness and impacts physical function. ALS, also known as Lou Gehrig's disease, causes nerve cells to gradually break down and die.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Amyotrophic Lateral Sclerosis (ALS) as diagnosed by a Physician. | **25%** |
| **Dementia (Including Alzheimer's Disease)** | *Condition Definition*<br>A progressive, degenerative disorder that attacks the brain's nerve cells or neurons, and may result in loss of memory, thinking, language skills, or behavioral changes.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or is Cognitively Impaired or becomes Totally Disabled for 90 days due to Dementia (including Alzheimer's Disease) as diagnosed by a Physician. | **25%** |
| **Huntington's Disease** | *Condition Definition*<br>A hereditary disease characterized by gradual loss of brain function and voluntary movement due to degenerative changes in the cerebral cortex and basal ganglia.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Huntington's Disease as diagnosed by a Physician. | **25%** |
| **Lupus** | *Condition Definition*<br>An autoimmune disease where the body's immune system attacks healthy tissue, leading to long-term inflammation. This disease is primarily characterized by joint pain and swelling.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Lupus as diagnosed by a Physician. | **25%** |

| | | |
|---|---|---|
| **Multiple Sclerosis (MS)** | *Condition Definition*<br>A chronic disease involving damage to the protective sheaths of nerve cells in the brain and spinal cord. Symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue. Eventually, the disease can cause the nerves themselves to deteriorate or become permanently damaged.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Multiple Sclerosis (MS) as diagnosed by a Physician. | **25%** |
| **Muscular Dystrophy** | *Condition Definition*<br>A genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Muscular Dystrophy as diagnosed by a Physician. | **25%** |
| **Myasthenia Gravis** | *Condition Definition*<br>A disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at the neuromuscular junction.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Myasthenia Gravis as diagnosed by a Physician. | **25%** |
| **Parkinson's Disease** | *Condition Definition*<br>A disease of the nervous system marked by tremor, muscular stiffness, and slow, imprecise movement. It is associated with degeneration of the basal ganglia of the brain and a deficiency of the neurotransmitter dopamine.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Parkinson's Disease as diagnosed by a Physician. | **25%** |
| **Systemic Sclerosis (Scleroderma)** | *Condition Definition*<br>A progressive autoimmune disease characterized by the hardening and tightening of the skin and connective tissues.<br><br>*Date of Diagnosis*<br>The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Systemic Sclerosis (Scleroderma) as diagnosed by a Physician. | **25%** |

| **Additional Benefits** | | **Percentage of Coverage Amount** |
|---|---|---|
| **Building Benefit** | *Benefit Definition* | **13 months** |

We will pay this benefit if an Insured is diagnosed with a critical illness. This benefit is based on the number of years an Insured is continuously covered under this certificate and is applied to total payable benefit for the critical illness. The applicable percentage amount will be calculated from an Insured's Coverage Effective Date to the Date of Diagnosis for the critical illness.

For purposes of this benefit, the Building Benefit is not applicable to a payable Be Well benefit.

*Benefit Duration*
This benefit is payable once per Insured per diagnosis.

**through 24 months 5%**

**25 months through 36 months 5%**

**37 months through 48 months 10%**

**49 months through 60 months 10%**

**61+ months 15%**

**Cancer Treatment and Care**

*Benefit Definition*
We will pay this benefit if an Insured receives a covered treatment within the United States for Invasive Cancer or Non-Invasive Cancer.

**10%**

For purposes of this benefit, the following Cancer Treatment and Care are eligible:

- Chemotherapy, consisting of one or more of the following:
  - chemotherapy treatments injected by medical personnel in a Physician's office, clinic or Hospital;
  - a prescription filled for Oral Chemotherapy;
  - a prescription filled for Topical Chemotherapy;
  - a pump for Chemotherapy initially filled or refilled;
  - a prescription filled for Chemotherapy to be injected by yourself or anyone other than personnel in a Physician's office, clinic or Hospital; or
  - a prescription filled for supportive and protective care drugs and colony stimulating factors.
- Radiation delivered by medical personnel in a Physician's office, clinic or Hospital;
- Confinement to a Hospital (including intensive care) or to an Observation Unit;
- Surgical Procedure performed by a Physician in a Hospital or Ambulatory Surgical Center; and
- Hospice care consisting of one or more of the following services received by an Insured for whom a Physician determines that cancer treatments are no longer of benefit and that an Insured is expected to live for only six months or less:
  - a visit from a representative of a Hospice care team at home;
  - the services of a Hospital on an Outpatient Basis under the direction of a Hospice;
  - a visit to a Hospice on an Outpatient Basis for treatment or services; and
  - Confinement to a Hospice care facility.

If the Insured's Invasive Cancer or Non-Invasive Cancer has a Date of Diagnosis before the Coverage Effective Date, coverage for that Invasive Cancer or Non-Invasive Cancer will apply only to treatment of Invasive Cancer or Non-Invasive Cancer commencing after this certificate has been in force for 12 months, unless the Invasive Cancer or Non-Invasive Cancer is excluded by name or specific description in this certificate.

*Benefit Duration*
This benefit is payable once monthly at 10% of the Percentage of Coverage Amount per Insured for covered treatments, up to a maximum of 100% of the Percentage of Coverage Amount per Insured.

| **Additional Critical Illnesses for your Children** | | **Percentage of Coverage Amount** |
|---|---|---|
| **Cerebral Palsy** | *Condition Definition*<br>A group of non-progressive disorders of movement and posture attributed to abnormal development of, or damage to motor control centers of the brain while a child's brain is still developing before, during, and immediately after birth. The motor disorders of Cerebral Palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and behavior, as well as seizures and secondary musculoskeletal problems.<br><br>*Date of Diagnosis*<br>The date a Physician makes or confirms an initial diagnosis of Cerebral Palsy after the moment of birth. | **100%** |
| **Cleft Lip or Cleft Palate** | *Condition Definition* | **100%** |

| | |
|---|---|
| Cleft Lip | A narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose, including unilateral clefting and bilateral clefting. |
| Cleft Palate | An opening between the roof of the mouth and the nasal cavity. |

*Date of Diagnosis*
The date a Physician makes or confirms an initial diagnosis of a Cleft Lip or Cleft Palate after the moment of birth.

| | | |
|---|---|---|
| **Congenital Heart Disease** | *Condition Definition*<br>A congenital disorder of the structure of the heart that includes a defect of the inside walls of the heart, the valves of the heart, or the large blood vessels that carry blood to and from the heart.<br><br>*Date of Diagnosis*<br>The date a Physician makes or confirms an initial diagnosis and recommends surgery of Congenital Heart Disease after live birth. | **100%** |
| **Cystic Fibrosis** | *Condition Definition*<br>A hereditary disorder affecting the exocrine glands. It causes the production of abnormally thick mucus, leading to the blockage of the pancreatic ducts, intestines, and bronchi and often resulting in respiratory infection.<br><br>*Date of Diagnosis*<br>The date the condition is first diagnosed by a Physician and supported by a sweat test with sweat chloride concentrations greater than 60 mmol/L. | **100%** |
| **Down Syndrome** | *Condition Definition*<br>A congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays. Down Syndrome includes: | **100%** |

| | |
|---|---|
| Trisomy 21 | An individual has three instead of two chromosome 21's. |
| Translocation | An extra part of chromosome 21 is attached to another chromosome. |
| Mosaicism | The individual has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21's. |

*Date of Diagnosis*
The date a Physician makes or confirms an initial diagnosis of Down Syndrome through the study of chromosome 21 after the moment of birth.

**Sickle Cell Anemia** — **100%**

*Condition Definition*
A disorder of the blood caused by inherited abnormal hemoglobin, which produces distorted (sickled) red blood cells.

For purposes of this benefit, sickle cell trait (sicklemia) does not meet the Condition Definition of Sickle Cell Anemia.

*Date of Diagnosis*
The date a Physician makes or confirms an initial diagnosis of Sickle Cell Anemia after live birth.

**Spina Bifida** — **100%**

*Condition Definition*
A congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina Bifida includes Meningocele or Myelomeningocele.

For purposes of this benefit, a diagnosis of spina bifida occulta does not meet the Condition Definition for Spina Bifida.

*Date of Diagnosis*
The date a Physician makes or confirms an initial diagnosis of Spina Bifida, Meningocele, or Myelomeningocele after the moment of birth.

**Type 1 Diabetes** — **100%**

*Condition Definition*
A chronic condition in which the pancreas produces little or no insulin, typically resulting from auto-immune destruction of the insulin-producing cells in the pancreas. Type 1 Diabetes is commonly referred to as juvenile diabetes or insulin-dependent diabetes.

*Date of Diagnosis*
The date a Physician makes or confirms the diagnosis of Type 1 Diabetes of a dependent that is supported by medical evidence, diagnostic testing, or confirmation of the cause of low insulin production.

This certificate is subject to all Exclusions and Limitations in this section, unless stated otherwise in a specific provision.

**Exclusions**

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation;
- being engaged in an illegal activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician;
- being Intoxicated;
- a Covered Loss that occurs while an Insured is incarcerated in a penal or correctional institution or under house arrest or confinement.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Continuity of Coverage will protect you, your Spouse, and your Children from having a lapse in insurance when your Employer changes insurance carriers to Unum from another insurance company. Continuity of Coverage also applies when your coverage changes from another carrier to Unum because the Employer merged with your prior employer or acquired your prior employer in whole or in part.

As used in this section, the following terms are defined as follows:
- Prior Policy means your Employer's prior insurance policy under which you, your Spouse, and your Children were insured on the day before the effective date of the Unum policy; and
- Prior Plan Benefits means the benefits that would have been paid to you, your Spouse, and your Children under the Prior Policy had that Prior Policy remained in force and you, your Spouse, and your Children had continued to be insured.

## Coverage Effective Date

**You are In Active Employment on the Policy Effective Date or on the Date your Eligible Group is First Covered**

You, your Spouse, and your Children will be insured under the Unum policy for the amount you had in force with the Prior Policy, provided you, your Spouse, and your Children:
- were covered under the Prior Policy on the day before the effective date of the Unum policy or on the date your Eligible Group is first covered due to the Employer merging with or acquiring your prior employer; and
- on the Unum Policy Effective Date or on the date your Eligible Group is first covered due to the Employer merging with or acquiring your prior employer, you are in Active Employment in an Eligible Group and satisfy any other eligibility requirements under the Unum policy.

If you were covered by the Prior Policy, you may increase or decrease coverage for an Insured subject to the Coverage Amounts available during an initial Enrollment Period.

**You are Not in Active Employment on the Policy Effective Date or on the Date your Eligible Group is First Covered Due to the Employer Merging with or Acquiring Your Prior Employer**

*Due to Injury or Sickness*

We will provide limited coverage under the Unum policy for you, your Spouse, and your Children provided you, your Spouse, and your Children would have been eligible to become insured under the Unum policy on the Policy Effective Date or on the date your Eligible Group is first covered due to the Employer merging with or acquiring your prior employer. You, your Spouse, and your Children will be insured under the Unum policy for the lesser of:
- the Prior Plan Benefits; or
- the benefits you, your Spouse, and your Children would be eligible for under the Unum policy less any benefits paid or payable by the Prior Policy.

Coverage under this provision will continue until the earliest of:
- the date you no longer meet the definition of an Injury or Sickness;
- the date you return to Active Employment; or
- in accordance with the End of Coverage provision.

Coverage for you, your Spouse, and your Children is subject to payment of required premium and all other provisions of the Unum policy.

On the date you return to Active Employment you, your Spouse, and your Children will be insured for coverage under the Unum policy.

*Due to Other Covered Extended Absences*

We will provide limited coverage under the Unum policy for you, your Spouse, and your Children provided you, your Spouse, and your Children would have been eligible to become insured under the Unum policy on the Policy Effective Date or on the date your Eligible Group is first covered due to the Employer merging with or acquiring your prior employer. You, your Spouse, and your Children will be insured under the Unum policy for the lesser of:
- the Prior Plan Benefits; or
- the benefits you, your Spouse, and your Children would be eligible for under the Unum policy less any benefits paid or payable by the Prior Policy.

If you are not in active employment due to a covered extended absence as outlined in the Continuation of Coverage During Extended Absences provision, we will consider your covered extended absence to have started on the effective date of the policy or on the date your Eligible Group is first covered due to the Employer merging with or acquiring your prior employer. Coverage under this provision will continue until the earliest of:

- the date you return to Active Employment;
- the earlier of:
  - the end of any covered extended absence covered under the Prior Policy; or
  - the end of any covered extended absence under the Continuation of Coverage During Extended Absences provision in the Unum policy; or
- in accordance with the End of Coverage provision.

Coverage for you, your Spouse, and your Children is subject to payment of required premium and all other provisions of the Unum policy.

On the date you return to Active Employment you, your Spouse, and your Children will be insured for coverage under the Unum policy.

**Waiting Period**

The Waiting Period is the continuous period of time you must be in an Eligible Group before you are eligible for coverage. Your Waiting Period is as follows:

If you are in an Eligible Group on or before November 1, 2025: 60 days
If you enter an Eligible Group after November 1, 2025: 60 days

**Coverage Eligibility Date**

The date on which you, your Spouse, and your Children become eligible for coverage.

*For you*

If you are in an Eligible Group, you are eligible for coverage on the later of:
- the Policy Effective Date; or
- the day after any applicable Waiting Period has been satisfied.

*For your Spouse*

If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Spouse.

*For your Children*

If you elect coverage for yourself, your Children are eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Child.

**Applying for Coverage**

**Initial Enrollment**

*Contributory Coverage*

You may apply for any coverage available for you, your Spouse, and your Children within 31 days of an Insured's Coverage Eligibility Date.

**Late Enrollment**

*Contributory Coverage*

If you do not apply for coverage during an Insured's Initial Enrollment or you voluntarily cancelled coverage for an Insured and are re-applying, you may apply for coverage during any scheduled Enrollment Period.

**Applying for Changes in Coverage**

*Contributory Coverage*

You may increase coverage for an Insured subject to the Coverage Amounts available during any scheduled Enrollment Period or within 31 days of a Qualifying Life Event.

Any increase in Coverage Amounts applied for as the result of a Qualifying Life Event, must be appropriate and consistent with the Qualifying Life Event.

You may also decrease coverage for an Insured subject to the Coverage Amounts available or cancel coverage for an Insured at any time during the Policy Year.

**Coverage Effective Date**

**Initial Enrollment**

*Contributory Coverage*

Coverage for an Insured will begin on the first day of the month coincident with or next following the later of:
- the Insured's Coverage Eligibility Date if you apply on or before that date; or
- the date you apply for the Insured's coverage, if coverage is applied for within 31 days of the Insured's Coverage Eligibility Date.

**Late Enrollment**

*Contributory Coverage*

Coverage for an Insured will begin on the first day of the next Policy Year.

**Coverage Effective Date for Changes in Coverage**

*Contributory Coverage*

Increases in coverage made during a scheduled Enrollment Period will begin on the first day of the next Policy Year.

Increases in coverage made due to a Qualifying Life Event will begin on the later of:

- the first day of the month coincident with or next following the date of a Qualifying Life Event, if you apply for the increase in coverage on or before that date; or
- the first day of the month coincident with or next following the date you apply for the increase in coverage if you apply within 31 days of the Qualifying Life Event.

Any decrease or cancellation in coverage made at any time during the Policy Year will begin on the first day of the month coincident with or next following the date you apply for the decrease or cancellation in coverage.

Any decrease or cancellation in coverage will not affect a Payable Claim that occurs prior to the decrease or cancellation.

**Coverage Effective Date for Plan Changes Requested by the Employer**

Changes in coverage due to a plan change requested by your Employer will begin on the date of the plan change.

**Coverage Effective Date if you are not in Active Employment**

You must be in Active Employment in order for coverage to become effective for any Insured in accordance with the Coverage Effective Date provision.

If you are not in Active Employment due to a covered extended absence as outlined under the Continuation of your Coverage During Extended Absences provision on the date coverage would become effective for any Insured, the Insured's Coverage Effective Date will be the date you return to Active Employment.

Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage is subject to this provision.

A delay of Coverage Effective Date for an increase in coverage will not affect coverage that is currently in force.

**Continuation of your Coverage During Extended Absences**

*Leave of Absence, other than a Family and Medical Leave of Absence*
You will be covered through the end of the month following 3 months from the date your Leave of Absence begins, provided premium is paid.

*Family and Medical Leave of Absence*
We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:
- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical Leave of Absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Waiting Period.

*Leave of Absence due to Injury or Sickness*
You will be covered, provided premium is paid.

**End of Coverage**

*For you*
Your coverage under this certificate ends on the earliest of:
- the date the policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue:
- while benefits are being paid;
- in accordance with the Continuation of your Coverage During Extended Absences provision; or
- if you elect to continue coverage for you, your Spouse, and your Children under Portability of Critical Illness Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

*For your Spouse*
Your Spouse's coverage will end on the earliest of:
- the date your coverage under this certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse may elect to continue Spouse and Children coverage, as long as premium is paid as required under Portability of Critical Illness Insurance.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this certificate.

*For your Children*
Your Children's coverage will end on the earliest of:
- the date your coverage under this certificate ends;

- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this certificate.

**Filing a Claim**

Provide notice of a claim for benefits under this certificate as soon as possible. If there are any questions on how to file a claim, please contact us or your Employer.

*Step 1 - Starting a Claim*

Notice of a claim may be provided in Writing, online at: **services.unum.com,** or by contacting us directly at 1-800-635-5597. Notice of a claim should be provided within 20 days from the date of the Covered Loss. If notice of a claim is not provided within this time period, it will not affect a Payable Claim as long as notice is provided as soon as reasonably possible.

*Step 2 - Claim Forms*

After receiving notice of a claim, we will send a claim form to you or your authorized representative within 15 days from the date we receive the notice of a claim. Claim forms may also be available from your Employer or from us online at: **services.unum.com**.

When you or your authorized representative receive the claim form, you or your authorized representative and your Employer must fill out your own section of the claim form and provide the Insured's Physician with the applicable section of the claim form. The Insured's Physician should complete their section of the form and send it directly to us.

If you or your authorized representative do not receive a claim form from us within 15 days after we receive notice of a claim, a Written statement from you or your authorized representative establishing the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be submitted online or sent to us by mail or fax:

Mailing Address: The Benefits Center
P.O. Box 100158
Columbia, South Carolina 29202-3158
Fax: (800)447-2498

*Step 3 - Proof of Loss*

Proof of Loss must be sent to us no later than 90 days after the date of Covered Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it will not affect a Payable Claim if it is provided within one year, unless the Insured lacks the legal capacity to do so.

In no event can Proof of Loss be submitted after the expiration of the time limit for commencing Legal Action as stated in this certificate, even if the failure to provide Proof of Loss is due to a lack of legal capacity or if state law provides an exception to the one year time period.

Proof of Loss, provided at your or your authorized representative's expense, must establish the nature and extent of the Covered Loss and should include but not be limited to the following:

- documentation of diagnosis or treatment provided by a Physician or medical facility and supported by clinical, radiological, histological, pathological, or laboratory evidence;
- it may also include one or more of the following:
  - a Physician's bill;
  - a Hospital bill; or
  - other proof of charges or services; and
- in the case of death, a certified copy of the death certificate, or other lawful evidence providing equivalent information.

If the Proof of Loss is not complete, we may require you to submit additional information.

After the Insured or the Insured's authorized representative have satisfied the

requirements of this provision, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured or the Insured's authorized representative of a claim decision and issue payment for a Payable Claim in accordance with the Payment of Benefits provision.

**Authorization for Release of Information**

We may require Written authorization from an Insured or an authorized representative to allow us to obtain necessary medical and non-medical information needed for Proof of Loss. Failure to provide us with Written authorization may result in the denial of a claim if the Insured or the authorized representative does not send proof to us and we are not able to obtain the proof required to make a claim decision.

**Right to Exam, Test, or Interview**

We may require the Insured to be examined or tested by one or more Physicians, other medical practitioners, or vocational experts of our choice. We may also require the Insured to be interviewed by an authorized representative of ours.

We have the right to interview the Insured and to have the Insured examined or tested as often as is reasonably necessary. Any examination, test, or interview that we require will be at our expense. If the Insured fails to attend or fully participate, we will not pay benefits or we will stop sending benefits under this certificate.

**Autopsy**

We will have the right, at our expense, to request an Autopsy where it is allowed by law.

**Payment of Benefits**

Benefits for which we are liable will be paid within 30 days after we have received Written Proof of Loss. All benefits will be paid to you, unless otherwise noted or unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits, refer to the Assignment provision in the General Provisions section of this certificate.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

**Beneficiary Designation and Change**

When a person becomes insured under this certificate, you are responsible for designating a primary and, if applicable, a contingent beneficiary in Writing for any benefits due in the event of the Insured's death. It is important to list the full name of each beneficiary and that all beneficiary designations are kept current and provided to us or the Employer. A beneficiary designation form may be available from the Employer or from us online at: **services.unum.com**.

You are the beneficiary for any Insured under this certificate while you are still living unless there is a valid change in beneficiary designation by an Insured. If you wish to change your beneficiary designation, you may do so by sending us or the Employer a completed, dated, and signed beneficiary designation change form. However, if you designated an irrevocable beneficiary, such beneficiary designation cannot be changed without the consent of the irrevocable beneficiary. Changes in beneficiary designations will take effect on the date notice of the beneficiary designation is signed by you.

Payment of Benefits will be administered based upon the currently available beneficiary designation on file with us or the Employer. If we have taken any action or made any payment before receiving notice of a beneficiary designation, that beneficiary designation will not go into effect for those actions taken or payments made.

If more than one beneficiary is named and the order or share of payments is not designated, the beneficiaries will share equally. The share of a beneficiary who dies before you, the share of a beneficiary who is legally unable to receive benefits, or the share of benefits that are unallocated will pass to any surviving beneficiaries in proportion to their current allocations. The aggregated shares of benefits in excess of 100% will be deducted from surviving beneficiaries in proportion to their current allocations. If you, or a

party legally acting on your behalf, has made an administrative error in completing the beneficiary designation form, we may, in our discretion, and when possible to do so, interpret the designation in a reasonable way to enable us to pay the benefits promptly.

If a beneficiary is not named, or if all named beneficiaries do not survive you, or the named beneficiary is legally unable to receive benefits, any benefits due will be paid to the first surviving family member in the order that follows:
- you;
- your Spouse;
- your natural offspring and legally adopted Children in equal shares;
- your mother or father, or if paying both, in equal shares; or
- your sisters and brothers in equal shares.

Instead of making a payment to a surviving family member, we have the right to pay any benefits due to your estate. If there are no surviving family members, or if we are unable to determine the appropriate beneficiary(ies), any benefits due will be paid to your estate. If there is no estate, benefits will be paid as required by law.

In the event of your death, should your Spouse survive you and elect to continue coverage under Portability of Critical Illness Insurance, your surviving Spouse should name a beneficiary according to the requirements specified within this provision.

**Payments to a Minor or Incompetent Insured or Insured's Beneficiary**

If an Insured or an Insured's beneficiary is a minor or is incompetent, we can pay up to $5,000 to the person or institution that appears to have assumed the custody and main support of the Insured, the minor, or the Insured's beneficiary unless or until that Insured, the minor, or the Insured's beneficiary's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again. Any such payment will reduce the Benefit Amount payable by us.

**Overpayment of Claims**

We have the right to recover any overpayments due to:
- fraud;
- misstatement of information;
- any error we make in processing a claim.

We must be reimbursed in full. If it is not possible to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

**Unpaid Premium**

Any Unpaid Premium due for an Insured's coverage at the time of payment for a claim may be deducted from the Insured's claim payment.

**Legal Actions**

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:
- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless applicable law requires us to afford a longer period within which to bring Legal Action.

**When Days Begin and End**

For the purpose of all dates under this certificate, all days begin at 12:01 a.m. and end at 12:00 midnight.

**Certificate of Coverage**

We will provide the Employer with a certificate for distribution to each insured Employee. The certificate describes:
- the coverage to which an Insured may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions, and requirements that apply to an Insured's coverage.

If the provisions of this certificate conflict with the provisions of the policy, the provisions of the policy will govern.

**Certificate of Coverage Contents**

Coverage for an Insured is provided under the provisions of this certificate. The provisions of this certificate are made part of the policy issued to the Policyholder.

The policy consists of all provisions of the policy, the provisions of this certificate, the Policyholder's application, and all related schedules, riders, amendments, and endorsements.

**Cancellation or Modification to the Policy and this Certificate of Coverage**

The policy and this certificate may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the policy or certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.

All policy and certificate modifications will take effect according to the provisions in the Start of Coverage section of this certificate.

**Policy Change Authority**

No other person, including a broker or agent, may change or waive any part of the policy. This Policyholder and Unum may mutually agree to change the policy at any time without the Insured's consent. No change to the policy will be effective unless signed by an officer of our company and endorsed on or attached to the policy.

**Representation in Applications**

Any statements made by you will be considered a representation and not a warranty. Such statements will not be used to avoid insurance, reduce benefits, or deny a claim unless they are included in an application in Writing from you.

**Assignment**

An Assignment transfers all or part of your legal title and rights under the policy and this certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the policy and this certificate if:
- the Written form has been signed by you and the assignee and the Assignment in its Written form is acceptable to us; and
- in our discretion, we may reject and have no obligation under an Assignment unless a signed or certified copy of the Written Assignment has been received and recorded by us prior to the loss.

An Assignment will take effect on the date you sign the Assignment. However, if we have taken any action or made any payment before we receive a notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made prior to our receipt of the notice of Assignment. Unless stated otherwise in, or allowed by the Assignment, the assignment does not change a beneficiary designation.

You are responsible for assuring the validity of any assignment. Please verify with your own legal counsel that your Assignment meets the legal requirements in your state.

**Contestability**

We will take legal or other action, if appropriate to do so, to cancel, to deny, or limit coverage or benefits based on statements made in signed applications for coverage, including Evidence of Insurability forms, only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of fraud, we can take legal or other action at any time as permitted by applicable law.

To confirm the accuracy of your signed application, we may require additional information,

including but not limited to completion of a medical treatment form and medical records.

**Misstatement of Information**

If we receive information about an Insured that is incorrect, we will:
- review the information to decide whether the Insured has coverage and in what amounts; and
- if necessary, make the applicable premium adjustments.

**Fraud**

We want to make sure you and your Employer do not incur additional insurance costs as a result of the effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime to defraud or attempt to defraud us into issuing coverage or paying benefits that we would otherwise not have issued or paid. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

Fraudulent and deceptive actions may result in denial of a claim, and may be subject to prosecution and punishment under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

**Agency**

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

**Workers' Compensation or State Disability Insurance**

This certificate does not provide coverage under any workers' compensation or state disability insurance law.

**Communicating With you or your Employer**

We may communicate verbally or in Writing with you or your Employer.

To protect our customers, we will abide by all applicable privacy laws and regulations.

**Privacy and Data Protection**

We will abide by all applicable privacy and data protection laws and regulations.

**Abdominal Aortic Aneurysm**

An Aneurysm located in the abdominal (lower) part of the aorta as confirmed by ultrasound, computerized tomography scan, magnetic resonance imaging, angiogram, or other reliable imaging techniques and which is:
- 5 centimeters or larger in size;
- is less than 5 centimeters and is rapidly expanding, and surgery has been recommended by a Physician; or
- is a Dissecting Aneurysm or a Ruptured Aneurysm.

**Active Employment**

You are working for your Employer for earnings that are paid regularly and you are performing the Material and Substantial Duties of your Regular Occupation. You must be regularly scheduled to work at least the minimum number of hours defined by your Employer.

Your work site must be:
- your Employer's usual place of business in the United States;
- an alternative work site in the United States at the direction of your Employer; or
- a location in the United States to which your job requires you to travel.

Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.

For purposes of this certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:
- inclement weather;
- power outages; and
- public health agency orders.

Temporary and seasonal workers are excluded from coverage.

**Activities of Daily Living (ADLs)**

A person is considered unable to perform an Activity of Daily Living if the activity cannot be performed safely without Substantial Assistance. Activities of Daily Living include the following:

| | |
|---|---|
| Bathing | The ability to wash oneself either in the tub, shower, or by sponge bath, with or without equipment or adaptive devices. |
| Dressing | The ability to put on and take off all garments, and medically necessary braces or artificial limbs usually worn including fastening or unfastening them. |
| Toileting | The ability to get to and from and on and off the toilet and to maintain a reasonable level of personal hygiene. |
| Transferring | The ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices including mechanical or motorized devices. |
| Continence | The ability to either voluntarily control bowel and bladder function; or if incontinent, be able to maintain a reasonable level of personal hygiene. |
| Eating | The ability to get nourishment into your body by any means once it has been prepared and made available to you. |

**Ambulatory Surgical Center**

A place which:
- is equipped for Surgical Procedures performed by a Physician;
- provides anesthesia administered by a licensed anesthesiologist or licensed nurse anesthetist; and
- has written agreements with local Hospitals to immediately accept patients who develop complications.

**Aneurysm**

A balloon-like bulge or weakening in the walls of an artery. An Aneurysm means any of the following:
- an Abdominal Aortic Aneurysm or Thoracic Aortic Aneurysm; or
- a Carotid Aneurysm, Cerebral Aneurysm or Renal Aneurysm where such Aneurysm is a Dissecting Aneurysm or Ruptured Aneurysm.

Aneurysm does not include an Aneurysm caused by a trauma.

**Carotid Aneurysm** An Aneurysm located in the portion of the carotid artery that is in the neck.

**Cerebral Aneurysm** An (intracranial or brain) Aneurysm located in an artery in the brain.

**Chemotherapy** Treatment with chemical substances that have a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of Invasive Cancer and Non-Invasive Cancer.

**Children** Any Child from the moment of birth to age 26 who is:
- your own natural offspring;
- your stepchild;
- your lawfully adopted Child as of the earliest of the date:
  - a petition is filed for you to adopt the Child; or
  - an adoption agreement, signed by you;
- a foster Child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- any child subject to our legal guardianship; or
- grandchildren, nieces, and nephews in a regular parent Child relationship; or
- any other Child for whom you are required by court or administrative order to provide coverage for.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be insured as both a Child and an Employee.

Your Children may not be insured by more than one Employee.

**Clinical Diagnosis** A diagnosis based on the study of symptoms that meets the following criteria:
- a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a Physician is treating the Insured for Invasive Cancer, Non-Invasive Cancer, or Skin Cancer.

**Cognitively Impaired or Cognitive Impairment** A deterioration or loss in intellectual capacity that requires another person's stand-by assistance or verbal cueing for an Insured's protection or for the protection of others. It is measured by clinical evidence and standardized tests which reliably measure impairment in:
- short or long term memory;
- orientation to people, places, or time; or
- deductive or abstract reasoning.

**Complications of Pregnancy** Abnormal conditions or concurrent diseases that significantly affects the pregnancy's usual medical management. A complication may exist during the pregnancy, during the delivery, or after the delivery.

**Confined** or **Confinement** Assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, for a minimum of 20 continuous hours on the advice of a Physician.

**Contributory Coverage**
Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.

**Coronary Artery Bypass Graft**
Undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

**Covered Accident**
An accident that is not specifically excluded by name or specific description in this certificate. The loss for which a claim is made must occur on or after the Insured's Coverage Effective Date.

**Covered Condition**
Any Sickness, diagnosis, or loss listed in the Critical Illness Details section.

**Covered Loss**
A Covered Condition or Covered Accident for which benefits are payable under this certificate.

**Date of Diagnosis**
The date a Physician confirms or a test proves that a Covered Condition exists. Date of Diagnosis requirements vary by Covered Condition.

**Dissecting Aneurysm**
A condition where a tear or split develops in a layer of an artery wall causing bleeding into and along the layers of the artery wall as confirmed by ultrasound, computerized tomography scan, magnetic resonance imaging, angiogram, or other reliable imaging techniques.

**Employee**
A person, also referred to as "you," or "your" who is in Active Employment in the United States with the Employer.

**Employer**
The Policyholder, including all covered United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whom premium is being paid.

**Enrollment Period**
A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.

**Hospice**
A program designed to provide palliative care and emotional support to the terminally ill in a home or homelike setting, or a facility so that quality of life is maintained.

**Hospital**
A licensed institution supervised by Physicians and operated pursuant to law on a full-time basis. The Hospital must:
- provide overnight care to people with Injuries or Sicknesses;
- have full-time Nurses on duty or on call who are supervised by a registered Nurse; and
- have X-ray equipment, a laboratory, and a surgical operating room at its locations or available to use on a pre-arranged basis.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a Hospice care facility;
- a Subacute Rehabilitation Unit or Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

**Injury** Any damage or harm to the body that is the direct result of an accident and not related to any other cause. Injuries that occur prior to an Insured's Coverage Effective Date will be treated as any other Sickness.

**Insured** Any person who has coverage under the policy.

**Leave of Absence** Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.

Normal vacation time, holidays, or temporary business closures is not considered a Leave of Absence.

**Material and Substantial Duties** Duties that:
- are routinely required for the performance of your Regular Occupation; and
- cannot be reasonably omitted or modified.

**Mental or Nervous Disorders** A psychiatric or psychological condition classified in the most recent *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) published by the American Psychiatric Association (APA), as of the date of Covered Loss. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the APA as of the date of Covered Loss. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, we will use a comparable diagnostic manual.

**Nurse** A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us.

**Observation Unit** A specified area within a Hospital, separate from the Emergency Department, where a patient can be monitored following a Surgical Procedure performed on an Outpatient Basis or treatment in the Emergency Department. The Observation Unit must:
- be under the direct supervision of a Physician or registered Nurse;
- be staffed by Nurses assigned specifically to that unit; and
- provide care seven days per week, 24 hours a day.

**Oral Chemotherapy** Chemotherapy taken by mouth.

**Outpatient Basis** Medical care and treatment received without being admitted to a Hospital or other facility.

**Pathological Diagnosis** A diagnosis made by a Pathologist based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards set up by the American Board of Pathology.

**Pathologist** A Physician licensed by the American Board of Pathology to practice pathological anatomy or a Physician certified by the Osteopathic Board of Pathology as an osteopathic pathologist.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Pathologist for a claim that you send to us.

**Payable Claim** A claim for which we are liable under the terms of the policy.

**Physician** A person performing tasks that are within the limits of their medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;

- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, children, parents, siblings, a past or present business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

**Plan** Your Employer's Critical Illness Welfare Benefit Plan under ERISA, which includes this certificate, your Employer's Group Critical Illness Insurance Policy, and other benefit plan documents consistent with this Plan.

**Policyholder** The entity to which the policy is issued.

**Qualifying Life Event** For coverage eligibility purposes, a Qualifying Life Event includes, but is not limited to:
- birth, adoption, or addition of a Child;
- a change in legal marital status;
- a change in employment status; or
- death of an Insured.

as permitted under Internal Revenue Code section 125.

Changes in coverage made as a result of a Qualifying Life Event must be consistent with the Qualifying Life Event.

For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy and plan documents.

**Radiation** The following treatments for the purpose of the destruction of malignant cells during the treatment of Invasive Cancer (not Skin Cancer):
- teleradiotherapy, using either natural or artificially propagated radiation; or
- interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources.

For purposes of this certificate, the following do not meet the Glossary definition of Radiation:
- office visits;
- laboratory tests;
- diagnostic X-rays;
- treatment planning;
- simulation;
- treatment devices;
- dosimetry;
- radiation physics;
- teletherapy;
- laser surgery; or
- other procedures related to these treatments.

**Regular Occupation** The occupation you are routinely performing when your Injury or Sickness begins. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer at a specific location.

**Renal Aneurysm** An Aneurysm located in the renal artery.

**Ruptured Aneurysm** A condition in which the Aneurysm bursts and causes bleeding inside the body as confirmed by ultrasound, computerized tomography scan, magnetic resonance imaging, angiogram, or other reliable imaging techniques.

**Sickness** An illness or disease.

**Spouse** The sole person who is your partner through lawful marriage, civil union, domestic

partnership (established by a declaration acceptable to us), or your legally separated Spouse.

Your Spouse may not be Insured as both a Spouse and an Employee.

**Substance Abuse**

Abuse of or addiction to drugs or alcohol.

**Substantial Assistance**

Physical, stand-by or verbal cueing assistance from another person, or adaptive devices which are required for the Insured to perform Activities of Daily Living.

**Surgical Procedure**

The cutting into the skin or other organ to accomplish any of the following goals:
- further explore the condition for the purpose of diagnosis;
- take a biopsy of a suspicious lump;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- repair an area that has been injured or affected by trauma, overuse, or Sickness; or
- restore proper function.

For purposes of this certificate, the following do not meet the Glossary definition of Surgical Procedure:
- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags; and
- foreign body removal from the eye.

**Thoracic Aortic Aneurysm**

An Aneurysm located in the thoracic (upper) part of the aorta as confirmed by ultrasound, computerized tomography scan, magnetic resonance imaging, angiogram, or other reliable imaging techniques and which is:
- 5 centimeters, or larger in size;
- is less than 5 centimeters and rapidly expanding, and surgery has been recommended by a Physician; or
- is a Dissecting Aneurysm or a Ruptured Aneurysm.

**Topical Chemotherapy**

Chemotherapy drug placed directly onto the skin.

**Total Disability or Totally Disabled**

The Insured is Totally Disabled when, as a result of a Covered Loss, the Insured is unable to perform with reasonable continuity the Material and Substantial Duties necessary to pursue the Insured's Regular Occupation.

**Traumatic Occupational Event**

The Insured's direct experience with or exposure to actual or threatened death, serious destruction, serious bodily harm, or sexual violence while performing the duties of their Regular Occupation that is:
- reported by the Insured to their Employer in accordance with the Employer's procedures and policies for such events; and
- investigated and reported by the Insured's Employer to appropriate authorities or entities in accordance with any applicable legislation, regulations, standards, or guidelines that apply to the Insured's Regular Occupation.

**Unum Insurance Company**

Referred to as "Unum" and "we," "us," and "our."

**Writing or Written**

A record on or transmitted by paper, electronic, or telephonic means consistent with applicable law.

## IMPORTANT NOTICES

**Questions regarding your policy or coverage should be directed to:**

**Unum Insurance Company**
**(877) 225-2712**

If you:
(a). need the assistance of the governmental agency that regulates insurance; or
(b). have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

**Questions regarding Grievances, including what a Grievance is and how to file, should be directed to:**

**Unum Insurance Company**
**2211 Congress Street**
**Portland, Maine 04122**
**ATTN: Customer Relations**

**Customer Relations Complaint Line (toll free): 1-800-321-3889, Option 2**

You may also contact the Indiana Department of Insurance by mail, telephone or electronically:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787

Consumer Hotline: (800) 622-4461; (317) 232-2396

**http://www.in.gov/idoi/3008.htm**

**Unum Insurance Company**
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

## Be Well Benefit

We encourage our Insureds to maintain a healthy lifestyle. For those who take precautionary measures by receiving routine health screenings, we offer a Be Well Benefit. This is an annual cash benefit that may be claimed after completing an eligible Be Well Screening, and may be used to help with monetary expenditures such as transportation, missed work, or other incidentals.

For the purpose of determining your coverage and eligibility for the Be Well Benefit, all terms and provisions of your Certificate of Coverage apply unless modified below.

**Policyholder:** Forest River, Inc.

**Policy Number:** 984568 011

**Policy Effective Date:** November 1, 2025

**Be Well Benefit Effective Date:** November 1, 2025

**Eligible Group(s)**

All Full Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

**Paying for Coverage**

The Be Well Benefit is automatically included in the cost of your Critical Illness Insurance coverage.

**Be Well Benefit**

| For You | For your Spouse | For your Children |
|---|---|---|
| $75 | $75 | $75 |

**Be Well Benefit Payment Conditions**

Each Insured is eligible to receive a maximum of one Be Well Benefit per Calendar year.

The Be Well Benefit will become payable provided the following conditions are met:
- the date of the Be Well Screening is after the Be Well Benefit Effective Date; and
- an Insured's coverage is in force.

**Be Well Screenings**

| | |
|---|---|
| Cholesterol and Diabetes | Eligible screenings include, but may not be limited to: blood test for triglycerides, fasting plasma glucose (FPG), fasting blood glucose test, hemoglobin A1C(HbA1c), Serum cholesterol test to determine total, HDL and LDL cholesterol levels, two hour post-load plasma glucose. |
| Cancer | Eligible screenings include, but may not be limited to: colonoscopy, virtual colonoscopy, CEA (blood test for colon cancer), low-dose computerized tomography (CT) (imaging study for lung cancer), double-contrast barium enema, fecal immunochemical testing, fecal DNA testing, PSA (blood test for prostate cancer), bone marrow testing, serum protein electrophoresis (blood test for myeloma), dermatological screenings for skin cancer, flexible sigmoidoscopy, hemoccult stool analysis, pap smear, thin prep pap test, cytology |

| | |
|---|---|
| | (PAP) smear, CA 15-3 (blood test for breast cancer), CA-125 (blood test for ovarian cancer), BRCA1 or BRCA2 testing. |
| Cardiovascular Function | Eligible screenings include, but may not be limited to: echocardiogram, electrocardiogram, stress test on a bicycle or treadmill, myocardial perfusion imaging. |
| Imaging Studies | Eligible screenings include, but may not be limited to: chest x-ray, carotid ultrasound (Doppler), mammography, breast ultrasound, breast MRI, breast thermography, transvaginal ultrasound, bone density scans, aortic ultrasound. |
| Annual Examinations by a Physician | Eligible examinations include sports physicals, annual exams for adults, and well-child visits. |
| Immunizations | Eligible immunizations include, but may not be limited to: HPV, Hepatitis B, chicken pox, MMR, meningitis, tetanus, pneumonia, influenza. |

**Unum Insurance Company**
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

# Portability of Critical Illness Insurance

Portability allows you, your Spouse and Children to continue coverage when coverage under the Employer's group Policy would otherwise end due to an Eligible Portability Event. The certificate in force at the time of an Insured's Eligible Portability Event will reflect the terms and conditions of the coverage that can be continued.

Portability of Critical Illness Insurance is made a part of the Critical Illness Insurance Policy and is subject to all of the provisions, limitations and exclusions of the Policy and certificate, unless changed by this document. Additionally, defined terms found within Portability of Critical Illness Insurance have been capitalized and have the same meaning as the terms in the Glossary section of the Certificate of Coverage.

Any future changes made in the Employer's group Policy will not apply to coverage an Insured has ported, unless required by law.

If you have any questions about portable coverage, please contact your Employer or us.

**Policyholder:** Forest River, Inc.

**Policy Number:** 984568 011

**Policy Effective Date:** November 1, 2025

**Portability Effective Date:** November 1, 2025

## Portability Provisions

**Eligible Portability Events**

You are eligible to port coverage on the date of the following Eligible Portability Events:
- your employment with your Employer ends; or
- you are no longer in an Eligible Group.

However, you will not be considered eligible to port coverage at the time of an Eligible Portability Event if the Employer's Policy is cancelled by us.

**Portable Coverage Available**

The amount of coverage in force for each Insured on the date of your Eligible Portability Event is available to port subject to the following:

*For you*
The maximum amount of coverage available to port is your in force Coverage Amount at the time of your Eligible Portability Event.

*For your Spouse*
The maximum amount of coverage available to port is your Spouse's in force Coverage Amount at the time of your Eligible Portability Event.

*For your Children*
The maximum amount of coverage available to port is your Children's in force Coverage Amount at the time of your Eligible Portability Event.

If you wish to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time you apply for portable coverage.

**Applying for Portable Coverage**

If you choose to apply for portable coverage for yourself, you may also port coverage for your Spouse and Children.

You must apply for portable coverage and pay the first premium within 31 days from the date of an Eligible Portability Event.

Applications for Portability are available from your Employer.

**Ported Coverage Effective Date**

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under your Employer's Policy.

**Changes to Ported Coverage**

You may decrease coverage for an Insured subject to the Coverage Amounts available at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

**End of Ported Coverage**

If you choose to cancel your ported coverage, coverage for all Insureds will end on the first of the month following the date you provide notification to us.

*For you*

Otherwise, your ported coverage will end on the earliest of:

- the date you fail to pay the required premium within 31 days of a premium due date;
- the date you are rehired by your Employer or return to an Eligible Group and are covered under the Employer's group Policy;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice; or
- the date you die.

*For your Spouse*

Your Spouse's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse has the option to port coverage in accordance with Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment.

*For your Children*

Your Children's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event your Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Critical Illness Insurance prior to the Employer's group Policy termination date will not be affected.

**Paying for**

You must make all premium contributions for ported coverage. We will bill you directly for

**Ported Coverage** any premium due.

**Rates for Ported Coverage** Premium will be based on the rates for Portability in effect on the date you apply to port coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

## Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment

**Eligible Portability Events for your Spouse** Your Spouse is eligible to port Spouse and Children coverage on the date of the following Eligible Portability Events for your Spouse:
- your death; or
- divorce or annulment.

**Portable Coverage Available** The amount of coverage in force for each Insured, on the date of the Eligible Portability Event for your Spouse, is available to port subject to the following:

*For your Spouse*
The maximum amount of coverage available to port is your Spouse's in force Coverage Amount at the time of the Eligible Portability Event for your Spouse.

*For your Children*
The maximum amount of coverage available to port is your Children's in force Coverage Amount at the time of the Eligible Portability Event for your Spouse.

If your Spouse wishes to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time your Spouse applies for portable coverage.

**Applying for Portable Coverage** If your Spouse chooses to apply for portable Spouse coverage, your Spouse may also apply for portable Children coverage.

Your Spouse must apply for portable coverage and pay the first premium within 31 days from the date of the Eligible Portability Event for your Spouse.

Applications for Portability are available from us.

**Ported Coverage Effective Date** Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under the Employer's Policy.

**Changes to Ported Coverage** Your Spouse may decrease their Spouse and Children coverage subject to the Coverage Amounts available at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

**End of Ported Coverage** If your Spouse chooses to cancel ported coverage, your Spouse and Children's coverage will end on the first of the month following the date your Spouse provides notification to us.

*For your Spouse*
Otherwise, your Spouse's ported coverage will end on the earliest of:
- the date your Spouse fails to pay the required premium within 31 days of a premium due date;

- the date your Spouse is no longer eligible for coverage;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice; or
- the date of your Spouse's death.

*For your Children*

Your Children's ported coverage will end on the earliest of:

- the date your Spouse's ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event your Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Critical Illness Insurance prior to the Employer's group Policy termination date will not be affected.

**Paying for Ported Coverage**

Your Spouse must make all premium contributions for Spouse and Children ported coverage. We will bill your Spouse directly for any premium due.

**Rates for Ported Coverage**

Premium will be based on the rates for Portability in effect on the date your Spouse applies to port Spouse and Children coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

## GROUP CRITICAL ILLNESS

**THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.**

State variations apply and are subject to change. Consult your Employer or plan administrator for the most current state provisions that may apply to you.

**Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.**

If you have a complaint about your insurance you may contact us at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene una queja acerca de su seguro puede comunicarse con nosotros a traves del numero 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of these states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

The state of **Montana** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the Insured resides on or after the Policy Effective Date.

**If you are a resident of one of the states noted below, and the provisions referenced below appear in your certificate in a form less favorable to you as an Insured, they are amended as follows:**

---

### For residents of Alaska

The **Filing a Claim** provision for *Claim Forms* in the **Claim Provisions** section of the certificate is amended so that claim forms will be sent to you within 10 working days from the date we receive the notice of a claim.

The **Filing a Claim** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days after receipt of satisfactory Written Proof of Loss.

A **Payment of Interest** provision is added to the **Claim Provisions** section of the certificate to read as follows:

> Any benefit payment issued after 30 days from the date we receive satisfactory Written Proof of Loss will accrue simple interest on the net benefit amount at the rate of 15% per year. Interest will accrue beginning on the day following the date that the benefit payment was due and ending on the date we make that benefit payment.
>
> For purposes of this provision, a benefit payment is considered paid on the date payment is mailed or transmitted electronically.

The **Overpayment of Claims** provision in the **Claim Provisions** section of the certificate is amended by limiting the right to recover overpayments to 365 days from the date the claim was paid. This provision is amended to read as follows:

> We have the right to recover any overpayments made on a prior claim up to 365 days from the date the claim was paid. However, in the event that we have clear and documented proof of Fraud or other intentional misconduct, we have the right to recover any overpayments at any time. In any event, we will provide Written notice at least 30 days before we seek recovery of an overpayment. Written notice will include adequate information to identify the specific claim and the specific reason for the recovery.

We must be reimbursed in full. If it is not possible to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

The **Confined** o**r Confinement** definition in the **Glossary** section of the certificate is amended to read as follows:

Assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, on the advice of a Physician.

**For residents of Arkansas**

The **Children** definition in the **Glossary** section of the certificate is amended for a Child who is incapable of self-sustaining employment due to permanent intellectual or physical incapacity to read as follows:

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us in order to continue coverage that would have otherwise ended due to age. Ongoing proof of incapacity and dependency must be provided, at our expense, when requested by us.

**For residents of Idaho**

The *Date of Diagnosis* for **End Stage Renal (Kidney) Failure**, a Covered Condition found under **Critical Illnesses** in the **Critical Illness Details** section of the certificate is amended to read as follows

The date the Physician diagnoses the Insured as having End Stage Renal (Kidney) Failure.

The *Condition Definition* and *Date of Diagnosis* for **Major Organ Failure**, a Covered Condition found under **Critical Illnesses** in the **Critical Illness Details** section of the certificate is amended to read as follows:

Irreversible and end-stage failure of the heart, liver, both lungs, or pancreas.

The date a Physician diagnoses the Insured as having Major Organ Failure.

The *Date of Diagnosis* for **Addison's Disease**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Addison's Disease.

The *Date of Diagnosis* for **Amyotrophic Lateral Sclerosis (ALS)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Amyotrophic Lateral Sclerosis (ALS).

The *Date of Diagnosis* for **Dementia (including Alzheimer's Disease)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date the Insured is Cognitively Impaired due to Dementia (including Alzheimer's Disease) as diagnosed by a Physician.

The *Date of Diagnosis* for **Huntington's Disease**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Huntington's Disease.

The *Date of Diagnosis* for **Lupus**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Lupus.

The *Date of Diagnosis* for **Multiple Sclerosis (MS)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Multiple Sclerosis (MS). The diagnosis must be supported by one or more of the following:
- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The *Date of Diagnosis* for **Muscular Dystrophy**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Muscular Dystrophy.

The *Date of Diagnosis* for **Myasthenia Gravis**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Myasthenia Gravis.

The *Date of Diagnosis* for **Parkinson's Disease**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Parkinson's Disease. The Insured must exhibit two or more of the following clinical manifestations for a period of at least 90 days:
- muscle rigidity;
- tremor; and
- bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses).

The *Date of Diagnosis* for **Systemic Sclerosis (Scleroderma)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Systemic Sclerosis (Scleroderma).

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended to read as follows:

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:
- participation in a felony;
- being engaged in an illegal occupation;
- being engaged in an illegal activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of alcohol or drugs or treatment for alcoholism or drug addiction unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Children** definition in the **Glossary** section of the certificate is amended to read as follows:

Any Child from live birth to age 26 who is:
- your own natural offspring;
- your Spouse's or Domestic Partner's Child;

- your lawfully adopted Child as of the earlier of;
  - the date the Child is physically placed with you in your care; or
  - the date you sign an adoption agreement that includes your binding obligation to assume financial responsibility for the child, if physical placement is prevented due to the medical needs of the child;
- a foster Child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent Child relationship that are dependent on you for primary financial support; or
- any other Child residing with you through legal mandate who is receiving more than one half of their primary financial support from you or your Spouse or Domestic Partner.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to an intellectual disability or physical disability prior to reaching age 26 and is dependent upon you for support and maintenance. Coverage for your Child will be continued subject to the End of Coverage provision.

You must submit proof of the Child's disability and dependency to us within 31 days of the Child's 26th birthday or we will accept proof within 31 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. During the first two years following the Child's 26th birthday or Coverage Eligibility Date, additional proof of a disability and dependency may be required at reasonable intervals. After this two year period, subsequent proof may be required but not more than once a year.

Your Children may not be insured as both a Child and an Employee.

Your Children may not be insured by more than one Employee.

**For residents of Louisiana**

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended to read as follows:

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:
- committing or attempting to commit a felony;
- being engaged in an illegal occupation;
- being engaged in an illegal activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of or treatment for voluntary use of any intoxicants or narcotics, unless administered on the advice of prescription or non-prescription drug, poison, fume, or other chemical substance or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the manufacturer, or as prescribed or directed by the Insured's Physician;
- being intoxicated;
- a Covered Loss that occurs while an Insured is incarcerated in a penal or correctional institution, except when the insured is legally detained in a correctional facility and has not been adjudicated or convicted of a criminal offense, or under house arrest or confinement.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended in that we may be subject to a penalty, payable to you, of double the amount of benefits due to the Insured under the terms of the certificate during the period of delay should we issue any benefit payment after 30 days from the date we receive satisfactory proof. This penalty may also include attorney's fees to be determined by the court.

The **Children** definition in the **Glossary** section of the certificate for "any other Child residing with you through legal mandate that is dependent on you for financial support" is amended to read as follows:

- any other Child residing with you through legal mandate;

The **Children** definition in the **Glossary** section of the certificate is amended to include any other Child if placed following an execution of an act of voluntary surrender on the date on which the act of voluntary surrender becomes irrevocable.

**For residents of Minnesota**

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or occurs as a result of injuring oneself intentionally or attempting or committing suicide, whether sane or not, is amended by removing the phrase, "or attempting or committing suicide."

The **Filing a Claim** provision for *Starting a Claim* in the **Claim Provisions** section of the certificate is amended so that notice of a claim can be provided to us by any of our authorized agents.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended to read as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. Such statements will not be used to avoid insurance, reduce benefits, or deny a claim unless they are included in an application in Writing from you. Statements may not be used in contesting the validity of the insurance with respect to which the statements were made after the insurance has been in force before the contest for a period of two years during the Insured's lifetime.

An **Intoxicated** definition is added to the **Glossary** section of the certificate to read as follows.

The Insured's blood alcohol level or THC level exceeds the legal limit for operating a motor vehicle in the state where the Accident occurred.

**For residents of Montana**

For purposes of the *Date of Diagnosis* in "**Cerebral Palsy**", "**Cleft Lip or Cleft Palate**", "**Congenital Heart Disease**", "**Down Syndrome**", "**Sickle Cell Anemia**", or "**Spina Bifada**" under the **Additional Critical Illnesses for your Children** in the **Critical Illness Details** section of the certificate, Children are defined as any Children from birth to age 26.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended to read as follows:

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:

- convicted of committing or attempting to commit a felony;
- being engaged in an illegal occupation;
- being engaged in an illegal activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical substance or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician;
- being intoxicated;
- a Covered Loss that occurs while an Insured is incarcerated in a penal or correctional institution,or under house arrest or confinement.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Filing a Claim** provision for *Starting a Claim* in the **Claim Provisions** section of the certificate is amended so that notice of a claim should be provided within 180 days from the date of the Covered Loss.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid within 30 days after receipt of Written Proof of Loss.

A **Payment of Interest** provision is added to the **Claim Provisions** section of the certificate to read as follows:

Any benefit payment issued after 30 days from the date we receive satisfactory proof will accrue simple interest on the net benefit amount at the rate of 10 percent per year. Interest will accrue beginning on the 31st day and ending on the date we make the payment.

The **Overpayment of Claims** provision in the **Claim Provision** section of the certificate is amended by limiting the right to recover overpayments to 12 months from the date of payment. This provision is amended to read as follows:

We have the right to recover any overpayments for up to 12 months due to:
- Fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

The 12 months we have to recover overpayments will begin:
- for Fraud, on the date the Department of Insurance (DOI) determines insufficient evidence of Fraud exists. If we suspect a claim is overpaid as the result of Fraud, we will report the activity and evidence to the DOI;
- for reasons other than Fraud, including error, omissions, misstatement, misrepresentation, or concealment of information, on the date we have actual knowledge of the invalid claim, overpayment, or other incorrect payment. We will not request reimbursement of an unpaid claim not the result of fraud more than 24 months from the date of payment, regardless of the date we obtain actual knowledge of the invalid claim, overpayment, or other incorrect information.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended to read as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. Such statements will not be used to avoid insurance, reduce benefits, or deny a claim unless they are included in an application in Writing from you.

The **Children** definition in the **Glossary** section of the certificate is amended to read as follows:

Any Child from birth age 26 who is:
- your own natural offspring;
- your Spouse's child;
- your lawfully adopted Child as of the date the Child is placed in your physical custody for the purpose of adoption and must continue unless the placement of the Child is disrupted prior to legal adoption and the Child is removed from placement. Coverage at the time of placement must include the necessary care and treatment of medical conditions existing prior to the date of placement and may not impose a Pre-existing Condition exclusion;
- a foster Child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent Child relationship that are dependent on you for primary financial support; or
- any other Child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

**For residents of New Hampshire**

The **Contestability** provision in the **Policy Provisions** section of the Policy is amended to remove reference to Fraud. Language has been replaced to read as follows:

However, in the event of non-payment of premium by the Insured or the Policyholder, we can take action at any time under the provision titled Cancellation or Modification of this Policy by Us and as permitted by applicable law.

The *Benefit Definition* for **Cancer Treatment and Care**, a Covered Condition found under **Additional Benefits** in the **Critical Illness Details** section of the certificate is amended so that the number of months after the certificate has been in force is no more than six months.

The *Condition Definition* for **Infectious Disease**, a Covered Condition found under **Supplemental Critical Illnesses** in the **Critical Illness Details** section of the certificate, is amended for the number of days an Insured must be confined to a Hospital to read 7 or more consecutive days.

The *Date of Diagnosis* for **Occupational Human Immunodeficiency Virus (HIV) or Hepatitis**, a Covered Condition found under **Supplemental Critical Illnesses** in the **Critical Illness Details** section of the certificate, is amended for time periods to read as follows:

- an initial confirmatory antibody test is taken within 23 days of the Covered Accident and is negative for the presence of HIV or Hepatitis B, C, or D; and
- a follow-up confirmatory antibody test is taken between 180 and 270 days from the date of the initial confirmatory antibody test and is positive for HIV or Hepatitis B, C, or D.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and** Limitations section of the certificate is amended to read as follows:

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:

- participation in a felony;
- being engaged in an illegal occupation;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical substance or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Pre-existing** Condition provision in the **Critical Illness Details** section of the certificate is amended so that the number of months prior to the Insured's Coverage Effective Date referenced in that section is no more than 6 months. The number of months after the Insured's Coverage Effective Date referenced in that section is no more than 6 months. Pre-existing Condition requirements are not applicable to congenital anomalies of a Child.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended to read as follows:

> **Payment of Benefits**
> Benefits for which we are liable will be paid within 30 days after we receive written Proof of Loss. All benefits will be paid to you, unless otherwise noted or unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits, refer to the Assignment provision in the General Provisions section of this certificate.
>
> In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.
>
> In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Assignment** provision in the **General Provisions** section of the certificate is amended to reflect that in no event may an Insured's assignee be a healthcare provider.

The **Contestability** provision in the **General Provisions** section f the certificate is amended to remove reference to Fraud. The last sentence has been replaced to read as follows:

> However, in the event of non-payment of an Insured's premium, we can take action at any time under the provision titled Canncellation or Modification to the Policy and this Certificate of Coverage as permitted by applicable law.

If your certificate includes coverage for your Child to be continued past the age limit for Child coverage that would otherwise apply, the language specific to this coverage in the **Children or Child** definition in the **Glossary** section of the certificate is replaced as follows:

> Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.
>
> You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

The **Covered Accident** definition in the **Glossary** section of the certificate is amended to read as follows:

> An unintended or unforeseen bodily Injury sustained by an Insured, wholly independent of disease, bodily infirmity, or illness and which:
> - occurs on or after the Coverage Effective Date; and
> - occurs while coverage is in force.

The **Injury** definition in the **Glossary** section of the certificate is amended to read "Any damage or harm to the body."

The **Nurse** definition in the **Glossary** section of the certificate is amended to read as follows:

> A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include an Advanced Practice Registered Nurse, a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us.

The **Be Well Benefit** is called the **Health Screening Benefit**.

**For residents of Ohio**

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended to read as follows:

**Payment of Benefits**
Benefits for which we are liable will be paid immediately after we have received Written Proof of Loss. All benefits will be paid to you[, unless otherwise noted or unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits, refer to the Assignment provision in the General Provisions section of this certificate.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

**For residents of South Carolina**

The **Autopsy** provision in the **Claim Provisions** section of the certificate is amended so that when we request an Autopsy it will be at our expense.

The **Legal Actions** provision in the **Claim Provisions** section of the certificate is amended to read as follows:

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to six years from the latest of when:
- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

Unless applicable law requires us to afford a longer period within which to bring Legal Action.

**For residents of South Dakota**

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended so that any exclusions for any Covered Loss that is caused by, contributed to by, or occurrs as a result of:

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician;
- being intoxicated;

are removed.

The **Physician** definition in the **Glossary** section of the certificate is amended to read as follows:

A person performing tasks that are within the limits of his or her medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, children, parents, siblings, a past or present business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us. This exclusion does not apply in those areas in which the above mentioned person is the only Physician in the area and acting within the scope of their normal employment.

**For residents of Texas**

An **Extension of Benefits** provision in the **Start of Coverage** section of the certificate is added to read as follows:

If coverage under this certificate ends while an Insured is disabled, the Insured's Group Critical Illness coverage may be continued, subject to the payment of premium, for up to the earliest of:

- the date the Insured is no longer disabled; or
- the date the Insured is covered for Group Critical Illness through another Employer.

Coverage ending will have no effect on benefits that would have otherwise been payable if this certificate had remained in force.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended to read as follows:

**Payment of Benefits**
Benefits for which we are liable will be paid within 60 days after we receive Written Proof of Loss. All benefits will be paid to you or to your assignee, refer to the Assignment provision in the General Provisions section of this certificate. Benefits for Children who are receiving financial and medical benefits through the Texas Health and Human Services Commission will be paid to the Texas Health and Human Services Commission whenever:

- the Texas Health and Human Services Commission is paying benefits pursuant to Chapters 31 and 32 of the Human Resources Code, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code;
- the parent who is covered by this certificate has possession or access to the Child pursuant to a court order, or is not entitled to access or possession of the Child and is required by the court to pay child support; and
- we are notified at the time of claim that the Child is receiving financial and medical assistance.

In addition, benefits for Children may also be paid to a possessory or managing conservator of the Child if the appointment for that Child was issued by a court in this or another state.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision or, if required, to the Texas Health and Human Services Commission.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended to read as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. The validity of this certificate may not be contested after it has been in force for two years after its date of issue. A statement made by you may not be used in contesting the validity of the insurance with respect to which the statement was made:

- after the insurance has been in force before the contest for two years during your lifetime; and
- unless the statement is contained in an application or is contained in a written instrument signed by you, and a copy of the signed application or written instrument containing the statement has been provided to you. If the statement was made by you and you have become incapacitated or died, a copy of the signed application or written instrument containing the statement will be provided to your beneficiary or your authorized representative.

The **Assignment** provision in the **General Provisions** section of the certificate is amended to read as follows.

An Assignment transfers all benefits payable under this certificate to someone else, known as an "assignee." We will recognize your assignee(s) under this certificate if:

- the Written form has been signed by you and the assignee and the Assignment in its Written form is acceptable to us; and

- in our discretion, we may reject and have no obligation under an Assignment unless a signed or certified copy of the Written Assignment has been received and recorded by us.

You may assign benefits payable under this certificate to a healthcare provider for which such benefits are payable.

An Assignment will take effect on the date you sign the Assignment. However, if we have taken any action or made any payment before we receive a notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made prior to our receipt of the notice of Assignment. Unless stated otherwise in, or allowed by the Assignment, the assignment does not change a beneficiary designation.

You are responsible for assuring the validity of any assignment.

The **Children** definition in the **Glossary** section of the certificate is amended to read as follows:

Any Child from live birth to age 26 who is:
- your own natural offspring;
- your Spouse's Child;
- your lawfully adopted Child once a petition is filed for you to adopt the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren;
- any other child residing with you through legal mandate; or
- any other child for whom you are required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be insured as both a Child and an Employee.

Your Children may not be insured by more than one Employee.

The **Total Disability or Totally Disabled** definition in the **Glossary** section of the certificate is amended to read as follows:

The Insured is Totally Disabled when, as a result of a Covered Loss, the Insured is unable to perform with reasonable continuity the Material and Substantial Duties necessary to pursue the Insured's Regular Occupation. The Insured is Totally Disabled when they are Confined in a Hospital for treatment of a Critical Illness.

**For residents of Utah**

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended by providing that any exclusion for any Covered Loss that is caused by, contributed to by, or occurs as a result of committing or attempting to commit a felony; being engaged in an illegal occupation or activity; or active participation in a riot, insurrection, or terrorist activity is applied only if you were a voluntary participant.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate for the "being Intoxicated" exclusion is amended to read as follows:

- being Intoxicated in violation of a law. For purposes of this exclusion, "intoxicated" means the insured's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

The **End of Coverage** provision in the **End of Coverage** section *For your Children* of the certificate is amended to read as follows:

Your Children's coverage will end on the earliest of:
- the date your coverage under this certificate ends;
- the end of the month in which your Children are no longer eligible for coverage; or
- the end of the month in which your Children no longer meet the definition of Children.

The **Children** definition in the **Glossary** section of the certificate is amended to read as follows:

Any Child from the moment of birth to the end of the month in which they reach age 26 who is:
- your own natural offspring;
- your Spouse's child;
- your lawfully adopted Child as of the earliest of the date:
  - the child is placed in your care or in a medical facility. If placement for adoption occurs within 30 days of the child's birth, coverage begins from the moment of birth. If placement for adoption occurs 30 days or more after the child's birth, coverage begins from the date of placement;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent child relationship that are dependent on you for primary financial support; or
- any other child for whom you are required by court or administrative order to provide coverage for.

Coverage for your Child may be continued past the end of the month in which they reach age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

The **Hospital** definition in the **Glossary** section of the certificate is amended to read as follows:

An institution licensed as a hospital and operating within the scope of its license and provides medically necessary hospital confinement or treatment for sick or injured people.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a Hospice care facility;
- a Subacute Rehabilitation Unit or Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Nurse** definition in the **Glossary** section of the certificate is amended to be defined as a healthcare professional trained, duly licensed, and operating within the scope of their license to care for people with Injuries or Sicknesses.

The **Pathological Diagnosis** definition in the **Glossary** section of the certificate is amended to read as follows:

A diagnosis made by a Physician based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards set up by the American Board of Pathology.

The **Physician** definition in the **Glossary** section of the certificate is amended to read as follows:

A person performing tasks that are within the limits of his or her medical license.

We will not recognize you, your Spouse, children, parents, siblings, a past or present business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

**For residents of Vermont**

The minimum hours requirement of the **Eligible Groups** provision in the **Critical Illness Highlights** section of the certificate is amended to cover eligible employees working at least 17.5 hours per week.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended by providing that any exclusion for any Covered Loss that is caused by, contributed to by, or occurs as a result of oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended so that any exclusions for any Covered Loss that is caused by, contributed to by, or occurs as a result of:

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician; and
- being intoxicated;

are removed.

The **Autopsy** provision in the **Claim Provisions** section of the certificate is amended so that when we request an Autopsy where it is allowed by law, and not prohibited by the Insured's religion, it will be at our expense.

The **Fraud** provision in the **General Provisions** section of the certificate is amended to read as follows:

We want to make sure you and your Employer do not incur additional insurance costs as a result of the effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

We will pursue all appropriate legal remedies in the event of insurance fraud.

The **Covered Accident** definition in the **Glossary** section of the certificate is amended to read as follows:

A bodily Injury sustained by an Insured, which is the direct cause of the loss, independent of disease or bodily infirmity and which:
- occurs on or after the Coverage Effective Date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

The **Hospital** definition in the **Glossary** section of the certificate is amended to remove the following criteria from what does not meet the Glossary definition of Hospital:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

**For residents of Wisconsin**

A **Grievance Procedure** provision is added to the **Claim Provisions** section of the certificate to read as follows.

Once you have received a decision on your claim or notice of coverage termination you have the right to submit a Written Grievance. Within five business days of receiving your Grievance, we will deliver or deposit in the mail to you or your authorized representative a Written acknowledgement confirming receipt of your Grievance. We will promptly investigate your Grievance.

If a Grievance is filed by you or on your behalf, you or your authorized representative have the right to appear in person before a Grievance panel to present Written or oral information. Prior to appearing before the Grievance panel, you or your authorized representative may submit written questions to the person(s) responsible for making the decision on your claim or to terminate your coverage.

We will provide you or your authorized representative with Written notification of the time and place of any Grievance panel meeting at least seven calendar days before the meeting and will make reasonable accommodations to allow you or your authorized representative to participate in the meeting.

The Grievance panel will consist of at least one person authorized to take corrective action on your Grievance, and, to the extent reasonably possible, at least one insured other than you who is not an Employee of the plan. The panel will not include the person who made the initial decision. Provided the panel consists of at least three persons, it may then include no more than one subordinate of the person who made the initial decision on your claim. Additionally, the panel may consult with the decision-maker and, if appropriate, a licensed health care provider with expertise in the field relating to your Grievance.

We will provide you and your authorized representative with Written notification of the disposition of your Grievance and any corrective action taken on your Grievance within 30 days of our receipt of your Grievance. Such notification will be signed by one voting member of the panel and will include a Written description of position titles of panel members involved in making the decision. If we are unable to resolve your Grievance within 30 calendar days, we may extend the time period by an additional 30 calendar days. If such an extension is needed, we will provide you and your authorized representative with Written notification which will include the reason additional time is needed and when resolution of your Grievance may be expected.

After the Grievance procedure is concluded, you may have a right to an independent review of any determination by us that the treatment provided does not meet the policy's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. You must request an independent review within four months after you receive notification of the disposition of your Grievance. You may request the review by providing Written notice to us of your request for the independent review and the independent review organization selected by you to conduct the review. Upon your request, we will provide you a copy of the listing of certified independent review organizations, or you may request the listing from the Commissioner of Insurance for the State of Wisconsin.

A **Grievance** definition is added to the **Glossary** section of the certificate to read as follows.

Any dissatisfaction with our provision of services or claim practices that is expressed to us in writing by you or on your behalf. It may include any of the following:

- provision of services;
- determination to reform or rescind a policy;
- determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders; or
- claim practices.

## ERISA

## Additional Summary Plan Description Information

If the Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the summary plan description. The summary plan description and the Policy constitute the Plan. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information contained in this document.

**Name of Plan:**
Forest River, Inc. Plan

**Name and Address of Employer:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514

**Plan Identification Number:**
a. Employer IRS Identification #: 20-3284366
b. Plan #: 0

**Type of Welfare Plan:**
Critical Illness

**Type of Administration:**
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

**ERISA Plan Year Ends:**
December 31

**Plan Administrator, Name, Address, and Telephone Number:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514
(534) 389-4600

Forest River, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

**Agent for Service of Legal Process on the Plan:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Insurance Company, 2211 Congress Street, Portland, Maine 04122, under 984568 011. Contributions to the Plan are made as stated under Paying for Coverage in the Certificate of Coverage.

**Employer's Right to Amend the Plan**
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying

policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in Writing and endorsed on or attached to the Plan.

**Employer's Right to Request Policy Change**

The Employer can request a Policy change. A change to the Policy will be made valid once approved by one of our officers. The change must be in Writing and endorsed on or attached to the Policy.

**Cancellation of the Policy by the Employer**

The Employer may cancel the Policy by providing us Written notice. In any event of cancellation, coverage will continue through the end of the day the cancellation takes effect.

A cancellation of the Policy will not affect a Payable Claim.

**Cancellation or Modification of the Policy by Us**

In addition, we may cancel or modify the Policy if the Policy terms are not met, the Employer fails to satisfy its obligations, premium is not paid, a change in the Employer or in the law impacts the benefits payable or the risks insured or, depending on the Policy, at our election after any rate guarantee period.

In any event, we will provide Written notice to the Employer prior to any cancellation or modification date. The Employer may cancel the Policy if it chooses not to accept the Policy modifications made by us.

A cancellation of the Policy will not affect a Payable Claim.

**Your Rights Under ERISA**

As a participant in the 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 the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon Written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps 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 pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's 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, if, for example, it finds your claim is frivolous.

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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

# Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

**COLLECTING INFORMATION**
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

**SHARING INFORMATION**
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

**SAFEGUARDING INFORMATION**
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

**ACCESS TO INFORMATION**
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

**CORRECTION OF INFORMATION**
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

**COVERAGE DECISIONS**
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

**CONTACTING US**
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

2020 Unum Group. All rights reserved. Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

unum.com MK-1883 (06-2020)

# NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

## Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

### Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

### Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

### Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

**The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**

**Unum Insurance Company**
2211 Congress Street
Portland, ME 04122

**INDIANA**
**INTERNAL GRIEVANCE AND EXTERNAL GRIEVANCE REVIEW PROCEDURE**

**CAREFULLY READ THE INFORMATION IN THIS DOCUMENT AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR BENEFITS**

If you or your authorized representative have questions about a Grievance, want to file a Grievance or want to appeal a Grievance decision, you or your authorized representative can contact us by calling our Customer Relations Complaint Line, toll free, at 1-800-321-3889, Option 2. Written notice may also be provided to: Unum Insurance Company, 2211 Congress Street, Portland, ME 04122, ATTN: Customer Relations.

You may also contact the Indiana Department of Insurance by calling the Consumer Hotline at 1-800-622-4461 or by writing to: State of Indiana Department of Insurance, Consumer Services Division, 311 West Washington Street, Suite 300, Indianapolis, Indiana 46204.

## Definitions

**GRIEVANCE** means any dissatisfaction expressed orally or in writing to us by you or by your authorized representative regarding the provision of services, claims practices, matters pertaining to the contractual relationship between:

a) an Insured and us; or
b) your Employer and us; or

a decision to rescind coverage under the Policy should you have a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

**EXTERNAL GRIEVANCE REVIEW** means a review conducted by a certified Independent Review Organization which is certified by the Indiana Office of the Commissioner of Insurance.

**APPEAL** means a formal request by you or your authorized representative for reconsideration of a decision not resolved to your satisfaction under the Grievance Procedures.

**ADVERSE DETERMINATION** means a reduction or denial of payment for treatment based on our review of the information provided and a determination by us that the treatment does not meet the requirements for the covered benefit.

## Internal Grievance

Upon receipt of a Grievance, we will provide acknowledgement, either orally or in writing, to you or your authorized representative within 5 business days.

A Grievance will be resolved within 20 business days after we receive all information necessary to complete our review. If additional information is needed, we will notify you or your authorized representative in writing of a 10 business day extension. This notice of extension will be sent to you before the end of the 20th business day. In the event of an extension, the Grievance will be resolved within 30 business days from the date we receive the Grievance.

Once the Grievance has been resolved, we will notify you in writing within 5 business days. Notification will include:

1. a statement of the decision along with the reasons, policies, and procedures that are the basis of the decision;
2. notice of your or your authorized representative's right to appeal the decision; and
3. the department, address and telephone number through which you or your authorized representative can contact us to obtain additional information about the decision or the right to appeal.

## Resolution of Appeals

If you or your authorized representative is not satisfied with the resolution of a Grievance, you or your authorized representative may Appeal the decision by notifying us at the above listed phone number or address. Upon receipt of an Appeal, we will provide acknowledgement, either orally or in writing, to you or your authorized representative within 5 business days.

In the case of an appeal of a Grievance decision of a determination that a service or proposed service is not appropriate or medically necessary or is experimental or investigational, we will appoint a panel of one or more qualified individuals to resolve your appeal. The panel will include one or more individuals who:

1. have knowledge of the medical conditions, procedures, or treatment at issue;
2. are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;
3. are not involved in the matter giving rise to the appeal or in the initial investigation of the Grievance; and
4. do not have a direct business relationship with the Insured or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the Grievance.

We will allow an Insured the opportunity to appear in person before, or if unable to appear in person, to appropriately communicate with the panel appointed.

A decision on an Appeal of a Grievance will be made as soon as reasonably possible but not later than 45 days after the Appeal of the Grievance is filed.

Once a decision on the Appeal has been made, we will notify you in writing within 5 business days. Notification will include:

1. a statement of the decision along with the reasons, policies and procedures that are the basis of the decision;
2. notice of your or your authorized representative's right to an External Grievance Review by an Independent Review Organization; and
3. the department, address and telephone number through which you or your authorized representative can contact us to obtain additional information about the decision or the right to an independent review.

## External Grievance Review

You or your authorized representative may file a written request for an External Grievance Review regarding: (1) an Adverse Determination of appropriateness; (2) an Adverse Determination of medical necessity; (3) a determination that a proposed service is experimental or investigational; (4) or our decision to rescind coverage. This request must be made within 120 days after receiving notification of our Appeal decision.

After receiving your request for an External Grievance Review, we will promptly forward the Grievance, along with all relevant information to an approved Independent Review Organization (IRO). For each external grievance filed with us, a different IRO will be selected from the list of independent review organizations that are certified by the Indiana Department of Insurance; and the choice of an IRO will be rotated among all certified independent review organizations before repeating a selection.

The IRO chosen will assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance. The IRO and the medical review professional conducting the external review may not have a material professional, familial, financial, or other affiliation with any of the following:

1. us;
2. any officer, director, or management employee of us;
3. the health care provider or the health care provider's medical group that is proposing the service;
4. the facility at which the service would be provided;
5. the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider; or
6. you or your authorized representative requesting the External Grievance Review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to you or your authorized representative and us before commencing the review and neither you or your authorized representative nor us objects.

You or your authorized representative will not pay any of the costs associated with the services of an independent review organization. All costs will be paid by us.

You or your authorized representative will:

1. not be subject to retaliation for exercising your right to an External Grievance;
2. be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
3. be permitted to submit additional information relating to the proposed service throughout the review process; and
4. cooperate with the IRO by:
    a. providing any requested medical information; or
    b. authorizing the release of necessary medical information.

We will cooperate with the IRO by promptly providing any information requested by the IRO.

If at any time during the external review, you or your authorized representative submits additional information which may result in us reconsidering our adverse decision, we will request that the IRO cease the External Grievance Review until our reconsideration is completed. We will complete our reconsideration within 15 days after the information is submitted. If our reconsideration continues to be adverse, you may request that the IRO resume the External Grievance review. We will forward the additional submitted information to the IRO within 2 business days after receipt of the information and request that the External Grievance review resumes to completion.

The IRO will make a decision to uphold or reverse our decision within 15 business days of the filed request based on information gathered from:

1. you or your authorized representative;
2. us;
3. the treating health care provider; and
4. any additional information that the IRO considers necessary and appropriate.

The IRO will apply standards of decision making that are based on objective clinical evidence and the terms of your critical illness policy.

The IRO will notify you or your authorized representative and us of their decision within 72 hours from the date of their decision.

Upon receipt of a notice of an IRO's decision to reverse our decision, we shall immediately approve the coverage that was the subject of the decision, except for those services which may be specifically excluded under the Policy.

An external grievance decision is binding on us. You and your authorized representative may not file a subsequent request for external review involving the same decision for which you have already received an external grievance decision.

**Expedited External Grievance Review**

There may be situations where the normal External Grievance Review process may not apply. An Expedited External Grievance Review can be requested for a Grievance related to an illness, disease, condition, injury, or a disability if the time frame for a standard review would jeopardize your life or health or your ability to reach and maintain maximum function. For these situations, written request for an Expedited External Grievance Review must be made within 120 days after receiving notification of our Appeal decision.

After receiving your request for an Expedited External Grievance Review, we will promptly forward the Grievance, along with all relevant information to an approved Independent Review Organization (IRO) based on the standards for selection above.

You or your authorized representative will not pay any of the costs associated with the services of an Independent Review Organization. All costs will be paid by us.

You or your authorized representative will:

1. not be subject to retaliation for exercising your right to an External Grievance;
2. be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
3. be permitted to submit additional information relating to the proposed service throughout the review process; and

4. cooperate with the IRO by:
    a. providing any requested medical information; or
    b. authorizing the release of necessary medical information.

We will cooperate with the IRO by promptly providing any information requested by the IRO.
If at any time during the external review, you or your authorized representative submits additional information which may result in us reconsidering our adverse decision, we will request that the IRO cease the External Grievance Review until our reconsideration is completed. We will complete our reconsideration within 72 hours after the information is submitted. If our reconsideration continues to be adverse, you may request that the IRO resume the External Grievance review. We will forward the additional submitted information to the IRO within 2 business days after receipt of the information and request that the External Grievance review resumes to completion.

An IRO will make a decision to uphold or reverse our decision within 72 hours of the filed request based on information gathered from:
1. you or your authorized representative;
2. us;
3. the treating health care provider; and
4. any additional information that the IRO considers necessary and appropriate.

The IRO will apply standards of decision making that are based on objective clinical evidence and the terms of your critical illness policy.

The IRO will notify you or your authorized representative and us of their decision within 72 hours from the date of their decision.

Upon receipt of a notice of an IRO's decision to reverse our decision, we shall immediately approve the coverage that was the subject of the decision, except for those services which may be specifically excluded under the Policy.

An external grievance decision is binding on us. You and your authorized representative may not file a subsequent request for external review involving the same decision for which you have already received an external grievance decision.

# Forest River, Inc.

## Your Hospital Indemnity Plan

Policy No. 984569 013

Underwritten by Unum Insurance Company

10/22/2025

**Unum Insurance Company**
2211 Congress Street
Portland, ME 04122
(877) 225-2712
services.unum.com

## Group Hospital Indemnity Insurance Certificate of Coverage

We welcome you as a customer and are committed to providing quality service. This is your Hospital Indemnity Certificate of Coverage. Hospital Indemnity coverage can ease the potential financial impact of hospital stays and related procedures and treatments by providing benefits. This certificate describes your Hospital Indemnity benefits in detail.

**Policyholder:** Forest River, Inc.

**Policy Number:** 984569 013

**Policy Effective Date:** November 1, 2025

**Policy Anniversary:** January 1

**Governing Jurisdiction:** Indiana

This certificate is issued to you under the Policy which is a contract between us and the Policyholder. If the terms and provisions of this certificate are different from the Policy, the Policy will govern. A copy of the Policy may be made available to you upon request. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

All references to provisions, sections, and defined terms found within this certificate have been capitalized. If you have any questions about the terms and provisions of this certificate, please contact your Employer or us at (877) 225-2712 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

**This Certificate of Coverage provides limited benefits under the non-participating Policy. The limited benefits provided under this Certificate of Coverage are a supplement to major medical coverage and are not a substitute for major medical coverage or other minimal essential coverage as required by federal law.**

**This certificate contains certain proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an Insured from receiving benefits under this certificate. Please read your certificate carefully and keep it in a safe place.**

Your certificate includes notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the Indiana Department of Insurance at (800) 622-4461.

## Consumer Complaint Notice

**If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.**

## Table of Contents


**Hospital Indemnity Highlights** ..... **4**

Eligible Group(s) ..... 4

Paying for Coverage ..... 4

Schedule of Benefits ..... 4

**Hospital Indemnity Details** ..... **5**

Hospital Benefits ..... 5

Additional Inpatient Care Benefits ..... 6

Other Benefits ..... 7

**Hospital Indemnity Details | Exclusions and Limitations** ..... **8**

**Hospital Indemnity Details | Other Features** ..... **9**

**Start of Coverage** ..... **10**

**End of Coverage** ..... **12**

**Claim Provisions** ..... **14**

**General Provisions** ..... **18**

**Glossary** ..... **20**

**State Requirements** ..... **25**

Hospital Indemnity Insurance provides financial protection for an Insured by paying benefits if an Insured is hospitalized or becomes eligible for benefits payable under this certificate.

This section includes highlights of an Insured's coverage. Please refer to the **Hospital Indemnity Details** for further information on the benefits available.

**Eligible Group(s)**

All Full Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

**Paying for Coverage**

*For you*
*Contributory Coverage*
You must make premium contributions for your coverage.

*For your Spouse*
*Contributory Coverage*
You must make premium contributions for your Spouse's coverage.

*For your Children*
*Contributory Coverage*
You must make premium contributions for your Children's coverage.

**Schedule of Benefits**

The following Schedules of Benefits are available to you during an Enrollment Period. You will have the opportunity to apply for coverage for you, your Spouse, and Children.

The benefits an Insured may receive for a Payable Claim are listed in the Schedules of Benefits, subject to all other terms and provisions of this certificate. Amounts are the same for all Insureds, unless noted otherwise.

**Hospital Benefits**

| | Choice 1 | Choice 2 |
|---|---|---|
| Admission for Covered Accidents or Covered Sicknesses, or Childbirth | $2,500 | $1,500 |
| Admission for Covered Accidents or Covered Sicknesses, or Childbirth - Hospital ICU | $2,000 | $1,000 |
| Daily Stay | $250 | $150 |
| Daily Stay - Hospital ICU | $250 | $150 |
| Short Stay | $500 | $500 |

**Additional Inpatient Care Benefits**

| | Choice 1 | Choice 2 |
|---|---|---|
| Rehabilitation or Subacute Rehabilitation Unit | $250 | $250 |

**Other Benefits**

| | Choice 1 | Choice 2 |
|---|---|---|
| Well Child | $100 | $100 |

The information in this section provides details about the benefits that may be payable to you, any applicable Exclusions, and Other Features included in your coverage.

Benefits will only be payable for Covered Losses that occur on or after the Insured's Coverage Effective Date.

## Hospital Benefits

**Admission for Covered Accidents, Covered Sicknesses, or Childbirth**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured is admitted and Confined to a Hospital due to a Covered Accident, Covered Sickness, or Childbirth.

The Admission and Confinement must be within 180 days of the Covered Accident. There are no corresponding time requirements for a Covered Sickness.

This benefit will be paid in addition to any Admission - Hospital ICU, Daily Stay, and Daily Stay - Hospital ICU benefits.

For purposes of this benefit, the following Hospital services are not eligible:
- treatment in the Emergency Department;
- treatment on an Outpatient Basis; and
- any Confinement of less than 20 hours.

*Benefit Duration*

This benefit is payable up to a maximum of 4 days per Insured per Calendar Year.

We will pay an additional Admission benefit if, after an Insured is discharged from the Hospital:
- the Insured becomes Confined due to a different and unrelated Covered Accident or Covered Sickness; or
- the Insured becomes Confined more than 90 days after the last day of the previous period of Confinement for the same or a related condition.

**Admission for Covered Accidents, Covered Sicknesses, or Childbirth - Hospital ICU**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits if an Insured is admitted and Confined to a Hospital ICU due to a Covered Accident, Covered Sickness, or Childbirth.

The Admission and initial Confinement must be within 180 days of the Covered Accident. There are no corresponding time requirements for a Covered Sickness.

This benefit will be paid in addition to any Admission, Daily Stay and Daily Stay - Hospital ICU benefits.

*Benefit Duration*

This benefit is payable up to a maximum of 4 days per Insured per Calendar Year.

We will pay an additional Admission benefit if, after an Insured is discharged from the Hospital:
- the Insured becomes Confined due to a different and unrelated Covered Accident or Covered Sickness; or
- the Insured becomes Confined more than 90 days after the last day of the previous period of Confinement for the same or a related condition.

**Daily Stay**

*Benefit Description*

We will pay the amount shown in the Schedule of Benefits for each day an Insured is Confined in a Hospital due to a Covered Accident, Covered Sickness, or Childbirth.

The Confinement must begin within 180 days of the Covered Accident. There are no corresponding time requirements for a Covered Sickness.

This benefit will be paid in addition to any Admission, Admission - Hospital ICU and Daily Stay - Hospital ICU benefits.

For purposes of this benefit, the following Hospital services are not eligible:
- treatment in the Emergency Department;
- treatment on an Outpatient Basis; and
- any Confinement of less than 20 hours.

*Benefit Duration*
This benefit is payable up to a maximum of 30 days per Insured per Calendar Year.

**Daily Stay - Hospital ICU**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits for each day an Insured is Confined in a Hospital ICU due to a Covered Accident or Covered Sickness.

The Confinement must begin within 180 days of the Covered Accident. There are no corresponding time requirements for a Covered Sickness.

This benefit will be paid in addition to any Admission, Admission - Hospital ICU and Daily Stay benefits.

*Benefit Duration*
This benefit is payable up to a maximum of 15 days per Insured per Calendar Year.

**Short Stay**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if an Insured is treated on an Outpatient Basis due to a Covered Accident or Covered Sickness for minimum of 8 hours in any of the following facilities:
- Ambulatory Surgical Center;
- Emergency Department;
- Hospital; or
- Observation Unit.

The Short Stay must be within 180 days of the Covered Accident. There are no corresponding time requirements for a Covered Sickness.

Benefits for Short Stay will not be paid for any day that benefits are paid for Admission, Admission - Hospital ICU, Daily Stay and Daily Stay Hospital ICU.

*Benefit Duration*
This benefit is payable up to a maximum of 4 days per Insured per Calendar Year.

We will pay an additional Short Stay benefits if, after an Insured is discharged from any of the facilities described above:
- the Insured receives treatment on an Outpatient Basis due to a different and unrelated Covered Accident or Covered Sickness; or
- the Insured receives treatment on an Outpatient Basis more than 90 days after the date treatment was received for a previously paid Short Stay benefit for the same or related treatment.

## Additional Inpatient Care Benefits

**Rehabilitation or Subacute Rehabilitation Unit**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits for each day an Insured is Confined in a Rehabilitation or Subacute Rehabilitation Unit.

The Insured must be transferred to the Rehabilitation or Subacute Rehabilitation Unit for inpatient care immediately after a period of Confinement in a Hospital due to a Covered Accident or Covered Sickness.

Benefits for Rehabilitation or Subacute Rehabilitation Unit will not be paid for any day that benefits are paid for Admission, Admission - Hospital ICU, Daily Stay, or Daily Stay - Hospital ICU.

*Benefit Duration*
This benefit is payable up to a maximum of 30 days per Insured per Calendar Year.

## Other Benefits

**Well Child**

*Benefit Description*
We will pay the amount shown in the Schedule of Benefits if a Child insured under this certificate receives routine check-ups during their first year of life.

*Benefit Duration*
This benefit is payable up to a maximum of four days per Child before the Child reaches the age of one year. Each routine check-up must be separated by at least 30 days.

This Certificate is subject to all Exclusions in this section, unless stated otherwise in a specific provision.

**Exclusions**

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- being intoxicated;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
- any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
- Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
  - stroke, Alzheimer's disease, trauma, viral infection; or
  - other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

**Continuity of Coverage**

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date of this certificate.

Coverage is subject to payment of premium and all other terms of this certificate. If you are on a Leave of Absence on the Policy Effective Date of this certificate, we will consider your Leave of Absence to have started on that date and coverage will continue for the period provided for Leave of Absence under Continuation of your Coverage During Extended Absences in this certificate.

If you have not returned to Active Employment before any Insured's Covered Loss, any benefits payable will be limited to what would have been paid by the prior carrier.

**Newborn Coverage Feature**

Your newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered, and you do not need to notify us or pay any additional premium for the newly eligible Child.

**Waiting Period**

The continuous period of time you must be in an Eligible Group before you are eligible for coverage:

If you are in an Eligible Group on or before November 1, 2025: 60 days
If you enter an Eligible Group after November 1, 2025: 60 days

**Coverage Eligibility Date**

*For you*

If you are in an Eligible Group, you are eligible for coverage on the later of:
- the Policy Effective Date; or
- the day after any applicable Waiting Period has been satisfied.

*For your Spouse*

If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Spouse.

*For your Children*

If you elect coverage for yourself, your Children are eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire the Child.

**Enrolling for Coverage**

**Initial Enrollment**

*Contributory Coverage*

You may apply for any coverage available for you, your Spouse, and Children within 31 days of an Insured's Coverage Eligibility Date.

**Late Enrollment**

*Contributory Coverage*

If you did not apply for coverage during an Insured's Initial Enrollment or you voluntarily cancelled coverage for an Insured and are re-applying, you may apply for coverage during any scheduled Enrollment Period.

Coverage may be subject to Evidence of Insurability Requirements.

**Applying for Changes in Coverage**

*Contributory Coverage*

You may change your coverage by applying for a different Schedule of Benefits during any scheduled Enrollment Period or within 31 days of a Qualifying Life Event.

Any change in coverage applied for as the result of a Qualifying Life Event must be consistent with the Qualifying Life Event.

You may also cancel coverage for an Insured at any time during the Policy Year, during any scheduled Enrollment Period, or within 31 days of a Qualifying Life Event.

**Coverage Effective Date**

**Initial Enrollment**

*Contributory Coverage*

Coverage for an Insured will begin on the first day of the month coincident with or next following the later of:
- the Insured's Coverage Eligibility Date if you apply on or before that date; or
- the date you apply for the Insured's coverage, if coverage is applied for within 31 days of the Insured's Coverage Eligibility Date.

**Late Enrollment**

*Contributory Coverage*

Coverage for an Insured will begin on the first day of the next Policy Year.

**Coverage Effective Date for Changes in Coverage**

*Contributory Coverage*

Changes in coverage for an Insured will begin on the latest of:
- the first day of the next Policy Year;
- the first day of the month coincident with or next following the date of a Qualifying Life Event; or
- the first day of the month coincident with or next following the date you apply for the

change in coverage due to a Qualifying Life Event, if it's within 31 days of the Qualifying Life Event.

Any cancellation in coverage for an Insured will take effect on the first day of the month coincident with or next following the date the cancellation in coverage is made.

Any change or cancellation in coverage will not affect a Payable Claim that occurs prior to the change or cancellation.

**Coverage Effective Date if you are not in Active Employment**

You must be in Active Employment in order for coverage to become effective for any Insured in accordance with the Coverage Effective Date provision.

If you are not in Active Employment due to an Injury, Sickness, or Leave of Absence on the date coverage would become effective, the Insured's Coverage Effective Date will be the date you return to Active Employment.

Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage is subject to this provision.

A delay of Coverage Effective Date for a change in coverage will not affect coverage that is currently in force.

**Continuation of Your Coverage During Extended Absences**

*Leave of Absence, other than a Family and Medical Leave of Absence*

You will be covered through the end of the month following 3 months from the date your Leave of Absence begins, provided premium is paid.

*Family and Medical Leave of Absence*

We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical leave of absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Waiting Period.

*Injury or Sickness*

You will be covered for up to 3 months from the date your absence due to an Injury or Sickness begins, provided premium is paid.

**End of Coverage**

*For you*

If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the earliest of:

- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue:

- in accordance with the Continuation of your Coverage During Absences provision; or
- if you elect to continue coverage for you under Portability of Hospital Indemnity Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

*For your Spouse*

If, while your coverage is in force, you choose to cancel your Spouse's coverage under this certificate, your Spouse's coverage will end on the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end on the earliest of:

- the date your coverage under this certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse may elect to continue Spouse and Children coverage, as long as premium is paid as required under Portability of Hospital Indemnity Insurance.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this certificate.

*For your Children*

If, while your coverage is in force, you choose to cancel your Children's coverage under this certificate, your Children's coverage will end on the first of the month coincident with or next following the date you provide notification to your Employer.

Otherwise, your Children's coverage will end on the earliest of:

- the date your coverage under this certificate ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this certificate.

**Filing a Claim**

We encourage early notification of a claim for benefits under this certificate so that a claim decision can be made in a timely manner. If there are any questions on how to file a claim, please contact us or your Employer.

Step 1 - Starting a Claim

Notice of a claim may be provided in Writing, online at: **services.unum.com**, or by contacting us directly at 1-800-858-6843. Notice of a claim should be provided within 20 days from the date of the Covered Loss. If it is not reasonably possible to provide notice within this time period, it will not affect a Payable Claim if it is provided as soon as is reasonably possible.

*Step 2 - Claim Forms*

After receiving notice of a claim, we will send a claim form to you or your authorized representative within 15 days from the date we receive the notice of a claim. Claim forms may also be available from your Employer or from us online at: **services.unum.com**.

When you or your authorized representative receive the claim form, you or your authorized representative must fill out your own section of the claim form and provide the Insured's Physician with the applicable section of the claim form. The Insured's Physician should complete their section of the form and send it directly to us.

If you or your authorized representative do not receive a claim form from us within 15 days after we receive notice of a claim, a Written statement from you or your authorized representative as to the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be sent to us by mail or fax:

Mailing Address: The Benefits Center
P.O. Box 100158
Columbia, South Carolina 29202-3158
Fax: 1-800-447-2498

*Step 3 - Proof of Loss*

Proof of Loss must be sent to us no later than 90 days after the date of Covered Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it will not affect a Payable Claim if it is provided within one year, unless the Insured lacks the legal capacity to do so.

In no event can Proof of Loss be submitted after the expiration of the time limit for commencing Legal Action as stated in this certificate, even if the failure to provide Proof of Loss is due to a lack of legal capacity or if state law provides an exception to the one year time period.

Proof of Loss, provided at your or your authorized representative's expense, must establish the nature and extent of the Covered Loss and should include but not be limited to the following:

- documentation of diagnosis or treatment provided by a Physician or medical facility and supported by clinical, radiological, histological, pathological, or laboratory evidence;
- it may also include one or more of the following:
  - a Physician's bill;
  - a Hospital bill; or
  - other proof of charges or services; and
- in the case of death, a certified copy of the death certificate, or other lawful evidence providing equivalent information.

If the Proof of Loss is not complete, we will request additional information.

**Authorization for Release of**

We may request Written authorization from an Insured. This authorization may be required in order for us to obtain the necessary medical and non-medical information

**Information** needed for Proof of Loss. This information may include any appropriate financial records such as income tax returns. Failure to provide us with Written authorization may result in the denial of a claim if the Insured does not send proof to us and we are not able to obtain the proof that is required to make a claim decision.

**Right to Exam, Test, or Interview**

We may ask the Insured to be examined or tested by one or more Physicians, other medical practitioners, or vocational experts of our choice. We may also require the Insured to be interviewed by an authorized representative of ours.

We have the right to request exams or tests as often as it is reasonably necessary. Any exam, test, or interview that we require will be paid at our expense. If the Insured fails to attend or fully participate, we will not pay the benefits or we will stop sending benefits under this certificate.

**Autopsy**

We will have the right, at our expense, to request an Autopsy where it is allowed by law.

**Claim Procedures**

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a claim decision and issue payment for a Payable Claim in accordance with the Payment of Benefits provision.

If we determine additional time is needed to review a claim, we may extend this time period by 30 days. We will notify the Insured of the circumstances requiring a review extension and when we anticipate making a claim decision.

If a claim for benefits under this certificate is wholly or partially denied, we will provide notice of our decision in Writing. The notice will contain the following information:

- the specific reason(s) for the determination with reference to those provisions on which the decision is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary;
- procedures and time limits for appealing our decision, and the Insured's right to obtain information about those procedures;
- a statement describing the right to bring a lawsuit under Section 502(a) of ERISA following a claim determination; and
- a statement disclosing any internal rule, guidelines, protocol, or similar criteria used in making the decision (or a statement that such information will be provided free of charge upon request).

**Payment of Benefits**

Benefits for which we are liable will be paid immediately or within 30 days after we receive Written Proof of Loss. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

**Beneficiary Designation and Change**

When a person becomes insured under this certificate, the Insured is responsible for designating a beneficiary in Writing for any benefits due in the event of the Insured's death. It is important to list the full name of each beneficiary and that all beneficiary designations are kept current and provided to us or the Employer. A beneficiary designation form may be available from the Employer or from us online at: **services.unum.com**.

You are the Beneficiary for any Insured under this certificate while you are still living unless there is a valid change in beneficiary designation by an Insured. If an Insured wishes to change their beneficiary designation, they may do so by sending us or the Employer a completed, dated, and signed beneficiary designation change form. Changes

in beneficiary designations will take effect on the date notice of the beneficiary designation is signed by the Insured.

Payment of Benefits will be administered based upon the currently available beneficiary designation on file with us or the Employer. If we have taken any action or made any payment before receiving notice of a beneficiary designation, that beneficiary designation will not go into effect for those actions taken or payments made.

If more than one beneficiary is named and the order or share of payments is not designated, the beneficiaries will share equally. The share of a beneficiary who dies before an Insured, the share of a beneficiary who is legally unable to receive benefits, or the share of benefits that are unallocated will pass to any surviving beneficiaries in proportion to their current allocations. The aggregated shares of benefits in excess of 100% will be deducted from surviving beneficiaries in proportion to their current allocations.

If a beneficiary is not named, or if all named beneficiaries do not survive the Insured, or the named beneficiary is legally unable to receive benefits, any benefits due will be paid to the first surviving family member in the order that follows:
- you;
- the Insured's Spouse;
- the Insured's natural offspring and legally adopted children in equal shares;
- the Insured's mother or father in equal shares, if paying both; or
- the Insured's sisters and brothers in equal shares.

Instead of making a payment to a surviving family member, we have the right to pay any benefits due to the Insured's estate. If there are no surviving family members, any benefits due will be paid to the Insured's estate.

In the event of your death, should your Spouse survive you and elect to continue coverage under Portability of Hospital Indemnity Insurance, your surviving Spouse should name a beneficiary according to the requirements specified within this provision.

**Payments to a Minor or Incompetent Insured or Insured's Beneficiary**

If an Insured or an Insured's beneficiary is a minor or is incompetent, we can pay up to $5,000 to the person or institution that appears to have assumed the custody and main support of the Insured, the minor, or the Insured's beneficiary unless or until that Insured, the minor, or the Insured's beneficiary's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again.

**Overpayment of Claims**

We have the right to recover any overpayments due to:
- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

We will not recover more money than the amount we paid you.

**Unpaid Premium**

Any Unpaid Premium due for an Insured's coverage at the time of payment for a claim may be deducted from the Insured's claim payment.

**Appeal Procedures**

Any request to file an appeal of a wholly or partially denied claim must be sent to us in Writing within 180 days from the date of Written notice of our claim decision. You have the right to:
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit Written comments, documents, records, and other information relating to the claim to us.

Once we receive an Insured's appeal request, it will be assigned to an appeals specialist. The appeals specialist is a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, we will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained in connection with the denial of an Insured's claim, we will provide the Insured with the names of each such expert, regardless of whether the advice was relied upon.

We will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. We will notify the Insured of the appeal decision within 45 days from receipt of the Written request for review. If we determine additional time is needed to review the appeal request, we may extend this time period by an additional 45 days. We will notify the Insured if an extension is needed.

If any review extension is necessary due to the Insured's failure to provide the information necessary to make a decision, we will notify the Insured of the review extension and specifically describe what information is required. This information must be sent to us within the time specified from the date of our request. The 45 day review extension will begin on the date we receive the requested information.

If the Insured fails to provide us with the requested information within the specified time period, we will make a decision based on the information available to us at that time.

If an appeal is wholly or partially denied, we will provide notice in Writing. Notice of a denied appeal will contain the following information:

- the specific reason(s) for the denial with reference to those provisions on which the denial is based;
- a statement disclosing any internal rule, guidelines, protocol, or similar criteria used in making the decision (or a statement that such information will be provided free of charge upon request);
- a statement describing the right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the appeal decision;
- a statement that entitles the Insured, at their request, reasonable access to or copies of all documents, records, or other information relevant to the appeal decision free of charge; and
- the statement that "You or 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."

Unless there are special circumstances, this administrative appeal process must be completed before an Insured begins any Legal Action regarding a claim.

**Legal Actions**

The time limit on Legal Actions for a Covered Loss is subject to applicable law in the state where the Policy was issued.

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:

- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless otherwise provided under federal law.

**When Days Begin and End**

For the purpose of all dates under this Certificate of Coverage, all days begin at 12:01 a.m. and end at 12:00 midnight.

**Certificate of Coverage Contents**

Coverage for an Insured is provided under this Certificate of Coverage which is a part of the Policy issued to the Policyholder. The Policy consists of:

- all Policy provisions, and any riders, amendments and endorsements, and other attachments to the Policy;
- this Certificate of Coverage, and any riders, amendments and endorsements, and other attachments to this Certificate of Coverage;
- the Policyholder's application for group insurance; and
- Employee's signed applications, if applicable.

**Your Certificate of Coverage**

We will provide the Employer with a Certificate of Coverage for distribution to each Insured Employee. Your certificate describes:

- the coverage to which an Insured may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions, and requirements that apply to an Insured's coverage.

If any of the terms and provisions of this certificate are different than in the Policy, the Policy will govern.

**Cancellation or Modification to the Policy and this Certificate of Coverage**

The Policy and this Certificate of Coverage may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the Policy or certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.

All Policy and certificate modifications will take effect according to the Coverage Effective Date for Changes in Coverage provision.

**Representation in Applications**

Any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary.

**Assignment**

An Assignment transfers all or part of your legal title and rights under the Policy and this certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the Policy and this certificate if:

- the Written form has been signed by you and the assignee and the form is acceptable to us; and
- a signed or certified copy of the Written Assignment has been filed with us.

An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. An Assignment does not change an Insured's coverage or beneficiary designation.

We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.

**Contestability**

We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of Fraud, we can take Legal Action at any time as permitted by applicable law.

**Misstatement of Information**

If you or your Employer provides us information about an Insured that is incorrect, we will:

- use the facts to decide whether the Insured has coverage under this certificate and the Policy and in what amounts; and
- if necessary, make the applicable premium adjustments.

**Fraud**

We want to make sure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if anyone knowingly, and with intent to injure, defrauds, or deceives us. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

**Agency**

For purposes of the Policy, your Employer acts on their own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

**Workers' Compensation or State Disability Insurance**

This certificate does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**Communicating With you or your Employer**

We may provide notices, information, and other communications to you or your Employer in Written form.

To protect our customers, we will abide by all applicable privacy laws and regulations.

**Additional Services**

This certificate may include enrollment, risk management, financial protection, and other support services related to your Employer's benefit program.

**Active Employment**

You are working for your Employer for earnings that are paid regularly and you are performing the Material and Substantial Duties of your Regular Occupation. You must be regularly scheduled to work at least the minimum number of hours as determined by your Employer.

Your work site must be:
- your Employer's usual place of business in the United States;
- an alternative work site in the United States at the direction of your Employer; or
- a location in the United States to which your job requires you to travel.

Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.

For purposes of this certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:
- inclement weather;
- power outage; and
- public health agency orders.

Temporary and seasonal workers are excluded from coverage.

**Ambulatory Surgical Center**

A facility, separate from a Hospital, equipped for Physicians to perform Surgical Procedures on an Outpatient Basis and must:
- provide anesthesia administered by a licensed anesthesiologist or licensed nurse anesthetist; and
- have agreements with local Hospitals to immediately accept patients who develop complications.

**Calendar Year**

The period beginning on the Insured's Coverage Effective Date and ending on December 31 of the same year. For each following year, it is the period beginning on January 1 and ending on December 31.

**Certificate of Coverage**

The document issued to the Employee, also referred to as the "certificate," describing an Insured's benefits and rights under the Policy, including any riders, amendments and endorsements, and other attachments to this certificate and the Policy.

**Childbirth**

Birth of a child by routine vaginal delivery or non-emergency Cesarean section.

Childbirth or Complications of Pregnancy will be treated as any other Covered Sickness.

**Children**

Any child from the moment of birth to age 26 who is:
- your own natural offspring;
- your stepchild;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- any child subject to your legal guardianship; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group

policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

**Complications of Pregnancy** Abnormal conditions or concurrent diseases that significantly affect the pregnancy's usual medical management. A complication may exist during the pregnancy, during the birth, or after the birth.

Childbirth or Complications of Pregnancy will be treated as any other Covered Sickness.

**Confined** or **Confinement** Assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, for a minimum of 20 continuous hours on the advice of a Physician.

**Contributory Coverage** Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.

**Covered Accident** An accident that is not specifically excluded by name or specific description in this certificate. The loss for which a claim is made must occur on or after the Insured's Coverage Effective Date.

**Covered Loss** Any services and treatments provided for Covered Accidents and Covered Sicknesses for which benefits are payable under this certificate.

**Covered Sickness** A sickness that is not specifically excluded by name or specific description in this certificate. The loss for which a claim is made must occur on or after the Insured's Coverage Effective Date.

Childbirth or Complications of Pregnancy will be treated as any other Covered Sickness.

**Emergency Department** A specified area within a Hospital, or standalone facility that is affiliated with a Hospital, designated for the emergency care of accidental Injuries or Sicknesses. This area must:
- be staffed and equipped to handle trauma;
- be supervised and have treatment provided by Physicians; and
- provide care seven days per week, 24 hours per day.

**Employee** A person, also referred to as "you," who is in Active Employment in the United States with the Employer.

**Employer** The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.

**Enrollment Period** A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.

**Hospital** A licensed institution supervised by Physicians and operated pursuant to law on a full-time basis. The Hospital must:
- provide overnight care to people with Injuries or Sicknesses;
- have full-time Nurses on duty or on call who are supervised by a registered Nurse; and
- have X-ray equipment, a laboratory, and a surgical operating room at its locations or available to use on a pre-arranged basis.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation or Subacute Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

**Hospital ICU**

A specifically designated area of the Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care. The Hospital ICU must:
- be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient Confinement;
- be permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- be under close observation by a specially trained nursing staff assigned exclusively to the ICU on a 24 hour basis; and
- have a Physician assigned to the ICU on a full-time basis.

For purposes of this certificate, the following Hospital units meet the Glossary definition of Hospital ICU:
- Intensive Care Unit (ICU);
- Coronary Care Unit;
- Neonatal ICU;
- Pulmonary Care Unit;
- Burn Unit; and
- Transplant Unit.

**Injury**

Any damage or harm to the body that is the direct result of an accident and not related to any other cause. Injuries that occur prior to an Insured's Coverage Effective Date will be treated as any other Sickness.

**Insured**

Any person who has coverage under this certificate.

**Leave of Absence**

Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.

Normal vacation time, holidays, or temporary business closures are not considered a Leave of Absence.

**Material and Substantial Duties**

Duties that:
- are routinely required for the performance of your Regular Occupation; and
- cannot be reasonably omitted or modified.

**Mental or Nervous Disorders**

A psychiatric or psychological condition classified in the most recent *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) published by the American Psychiatric Association (APA), as of the date of Covered Loss. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the APA as of the date of Covered Loss. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, we will use a comparable diagnostic manual.

**Nurse**

A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us.

**Observation Unit**

A specified area within a Hospital, separate from the Emergency Department, where a patient can be monitored following a Surgical Procedure performed on an Outpatient Basis or treatment in the Emergency Department. The Observation Unit must:

- be under the direct supervision of a Physician or registered Nurse;
- be staffed by Nurses assigned specifically to that unit; and
- provide care seven days per week, 24 hours a day.

**Outpatient Basis** Medical care and treatment received without being admitted to a Hospital or other facility.

**Payable Claim** A claim for which we are liable for under the terms of this certificate.

**Physician** A person performing tasks that are within the limits of his or her medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

**Plan** Your Employer's Hospital Indemnity Welfare Benefit Plan under ERISA, which includes this certificate, your Employer's Group Hospital Indemnity Insurance Policy, and other benefit plan documents consistent with this Plan.

**Policy** The Group Hospital Indemnity Insurance Policy issued to the Policyholder, including this Certificate of Coverage and any riders, amendments and endorsements, and other attachments to this certificate and the Policy.

**Policyholder** The entity to which the Policy is issued.

**Qualifying Life Event** For coverage determination purposes, a Qualifying Life Event means an event including, but not limited to:
- birth, adoption, or addition of a Child;
- a change in legal marital status;
- a change in employment status; or
- death of an Insured.

Qualifying Life Event coverage changes made in accordance with the Start of Coverage provisions must be consistent with the Qualifying Life Event.

For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy.

**Regular Occupation** The occupation you are routinely performing. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer at a specific location.

**Rehabilitation Unit** An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. The care services provided by the Rehabilitation Unit must:
- consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by accidental Injury or Sickness to achieve the highest possible functional ability; and
- be provided by or under the supervision of an organized staff of Physicians.

The Rehabilitation Unit may be part of a Hospital or a standalone facility.

For purposes of this certificate, the following do not meet the Glossary definition of Rehabilitation Unit:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Subacute Rehabilitation Unit;

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

**Sickness**

An illness or disease.

**Spouse**

The person who is your partner through lawful marriage, civil union, domestic partnership (established by a declaration acceptable to us), or your legally separated Spouse.

Your Spouse may not be Insured as both a Spouse and an Employee.

**Subacute Rehabilitation Unit**

A licensed facility or distinct part of a facility supervised at all times by a Physician or Nurse. The facility must provide care to people with Injuries or Sicknesses on an inpatient basis. The Subacute Rehabilitation Unit must have a Physician available at all times and have a transfer agreement in effect with one or more participating Hospitals.

For purposes of this certificate, the following do not meet the Glossary definition of Subacute Rehabilitation Unit:

- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

**Substance Abuse**

Abuse of or addiction to drugs or alcohol.

**Surgical Procedure**

The cutting into the skin or other organ to accomplish any of the following goals:

- further explore the condition for the purpose of diagnosis;
- take a biopsy of a suspicious lump;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- repair an area that has been injured or affected by trauma, overuse, or Sickness; or
- restore proper function.

For purposes of this certificate, the following do not meet the Glossary definition of Surgical Procedure:

- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags; and
- foreign body removal from the eye.

**Unum Insurance Company**

Referred to as "Unum" and "we," "us," or "our."

**Writing** or **Written**

A record on or transmitted by paper, electronic, or telephonic means consistent with applicable law.

## IMPORTANT NOTICES

**Questions regarding your policy or coverage should be directed to:**

**Unum Insurance Company**
**(877) 225-2712**

If you:
(a). need the assistance of the governmental agency that regulates insurance; or
(b). have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

**Unum Insurance Company**
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

## Be Well Benefit

We encourage our Insureds to maintain a healthy lifestyle. For those who take precautionary measures by receiving routine health screenings, we offer a Be Well Benefit. This is an annual cash benefit that may be claimed after completing an eligible Be Well Screening, and may be used to help with monetary expenditures such as transportation, missed work, or other incidentals.

For the purpose of determining your coverage and eligibility for the Be Well Benefit, all terms and provisions of your Certificate of Coverage apply unless modified below.

**Policyholder:** Forest River, Inc.

**Policy Number:** 984569 013

**Policy Effective Date:** November 1, 2025

**Be Well Benefit Effective Date:** November 1, 2025

**Eligible Group(s)**

All Full Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

**Paying for Coverage**

The Be Well Benefit is automatically included in the cost of your Hospital Indemnity Insurance coverage.

**Be Well Benefit**

| For you | For your Spouse | For your Children |
|---|---|---|
| $50 | $50 | $50 |

**Be Well Benefit Payment Conditions**

Each Insured is eligible to receive a maximum of one Be Well Benefit per Calendar year.

The Be Well Benefit will become payable provided the following conditions are met:
- the date of the Be Well Screening is after the Be Well Benefit Effective Date; and
- an Insured's coverage is in force.

**Be Well Screenings**

| | |
|---|---|
| Cholesterol and Diabetes | Eligible screenings include, but may not be limited to: blood test for triglycerides, fasting plasma glucose (FPG), fasting blood glucose test, hemoglobin A1C(HbA1c), Serum cholesterol test to determine total, HDL and LDL cholesterol levels, two hour post-load plasma glucose. |
| Cancer | Eligible screenings include, but may not be limited to: colonoscopy, virtual colonoscopy, CEA (blood test for colon cancer), low-dose computerized tomography (CT) (imaging study for lung cancer), double-contrast barium enema, fecal immunochemical testing, fecal DNA testing, PSA (blood test for prostate cancer), bone marrow testing, serum protein electrophoresis (blood test for myeloma), dermatological screenings for skin cancer, flexible sigmoidoscopy, hemoccult stool analysis, pap smear, thin prep pap test, cytology |

| | |
|---|---|
| | (PAP) smear, CA 15-3 (blood test for breast cancer), CA-125 (blood test for ovarian cancer), BRCA1 or BRCA2 testing. |
| Cardiovascular Function | Eligible screenings include, but may not be limited to: echocardiogram, electrocardiogram, stress test on a bicycle or treadmill, myocardial perfusion imaging. |
| Imaging Studies | Eligible screenings include, but may not be limited to: chest x-ray, carotid ultrasound (Doppler), mammography, breast ultrasound, breast MRI, breast thermography, transvaginal ultrasound, bone density scans, aortic ultrasound. |
| Annual Examinations by a Physician | Eligible examinations include sports physicals, annual exams for adults, and well-child visits. |
| Immunizations | Eligible immunizations include, but may not be limited to: HPV, Hepatitis B, chicken pox, MMR, meningitis, tetanus, pneumonia, influenza. |

**Unum Insurance Company**
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

# Portability of Hospital Indemnity Insurance

Portability allows you, your Spouse, and Children to continue coverage when coverage under the Employer's group Policy would otherwise end due to an Eligible Portability Event. The certificate in force at the time of an Insured's Eligible Portability Event will reflect the terms and conditions of the coverage that can be continued.

Portability of Hospital Indemnity Insurance is made a part of the Hospital Indemnity Insurance Policy and is subject to all of the provisions, limitations and exclusions of the Policy and certificate, unless changed by this document. Additionally, defined terms found within Portability of Hospital Indemnity Insurance have been capitalized and have the same meaning as the terms in the Glossary section of the Certificate of Coverage.

Any future changes made in the Employer's group Policy will not apply to coverage an Insured has ported, unless required by law.

If you have any questions about portable coverage, please contact your Employer or us.

**Policyholder:** Forest River, Inc.

**Policy Number:** 984569 013

**Policy Effective Date:** November 1, 2025

**Portability Effective Date:** November 1, 2025

## Portability Provisions

**Eligible Portability Events**

You are eligible to port coverage on the date of the following Eligible Portability Events:
- your employment with your Employer ends; or
- you are no longer in an Eligible Group.

However, you will not be considered eligible to port coverage at the time of an Eligible Portability Event if the Employer's Policy is cancelled by us.

**Portable Coverage Available**

The amount of coverage in force for each Insured on the date of your Eligible Portability Event is available to port subject to the following:

*For you*
The maximum amount of coverage available to port is your in force coverage at the time of your Eligible Portability Event.

*For your Spouse*
The maximum amount of coverage available to port is your Spouse's in force coverage at the time of your Eligible Portability Event.

*For your Children*
The maximum amount of coverage available to port is your Children's in force coverage at the time of your Eligible Portability Event.

If you wish to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time you apply for portable coverage.

**Applying for Portable Coverage**

If you choose to apply for portable coverage for yourself, you may also port coverage for your Spouse and/or Children.

You must apply for portable coverage and pay the first premium within 31 days from the date of an Eligible Portability Event.

Applications for Portability are available from your Employer.

**Ported Coverage Effective Date**

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under your Employer's Policy.

**Changes to Ported Coverage**

You may decrease coverage for an Insured at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

**End of Ported Coverage**

If you choose to cancel your ported coverage, coverage for all Insureds will end on the first of the month following the date you provide notification to us.

*For you*

Otherwise, your ported coverage will end on the earliest of:

- the date you fail to pay the required premium within 31 days of a premium due date;
- the date you are rehired by your Employer or return to an Eligible Group and are covered under the Employer's group Policy;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice; or
- the date you die.

*For your Spouse*

Your Spouse's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse has the option to port coverage in accordance with Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment.

*For your Children*

Your Children's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event your Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Hospital Indemnity Insurance prior to the Employer's group Policy termination date will not be affected.

**Paying for Ported Coverage**

You must make all premium contributions for ported coverage. We will bill you directly for any premium due.

**Rates for Ported Coverage**

Premium will be based on the rates for Portability in effect on the date you apply to port coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

## Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment

**Eligible Portability Events for your Spouse**

Your Spouse is eligible to port Spouse and Children coverage on the date of the following Eligible Portability Events for your Spouse:

- your death; or
- divorce or annulment.

**Portable Coverage Available**

The amount of coverage in force for each Insured, on the date of the Eligible Portability Event for your Spouse, is available to port subject to the following:

*For your Spouse*

The maximum amount of coverage available to port is your Spouse's in force coverage at the time of the Eligible Portability Event for your Spouse.

*For your Children*

The maximum amount of coverage available to port is your Children's in force coverage at the time of the Eligible Portability Event for your Spouse.

If your Spouse wishes to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time your Spouse applies for portable coverage.

**Applying for Portable Coverage**

If your Spouse chooses to apply for portable Spouse coverage, your Spouse may also apply for portable Children coverage.

Your Spouse must apply for portable coverage and pay the first premium within 31 days from the date of the Eligible Portability Event for your Spouse.

Applications for Portability are available from us.

**Ported Coverage Effective Date**

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under the Employer's Policy.

**Changes to Ported Coverage**

Your Spouse may decrease their Spouse and Children coverage at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

**End of Ported Coverage**

If your Spouse chooses to cancel ported coverage, your Spouse and Children's coverage will end on the first of the month following the date your Spouse provides notification to us.

*For your Spouse*

Otherwise, your Spouse's ported coverage will end on the earliest of:

- the date your Spouse fails to pay the required premium within 31 days of a premium due date;
- the date your Spouse is no longer eligible for coverage;
- the date coverage provided under Portability is cancelled by us for any reason upon

45 days notice; or
- the date of your Spouse's death.

*For your Children*

Your Children's ported coverage will end on the earliest of:
- the date your Spouse's ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event the Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Hospital Indemnity Insurance prior to the Employer's group Policy termination date will not be affected.

**Paying for Ported Coverage**

Your Spouse must make all premium contributions for Spouse and Children ported coverage. We will bill your Spouse directly for any premium due.

**Rates for Ported Coverage**

Premium will be based on the rates for Portability in effect on the date your Spouse applies to port Spouse and Children coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

## GROUP HOSPITAL

**THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.**

State variations apply and are subject to change. Consult your Employer or plan administrator for the most current state provisions that may apply to you.

**Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.**

If you have a complaint about your insurance you may contact us at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene una queja acerca de su seguro puede comunicarse con nosotros a traves del numero 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of these states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

**If you are a resident of one of the states noted below, and the provisions referenced below appear in your certificate in a form less favorable to you as an Insured, they are amended as follows:**

---

### For residents of Alaska

The **Filing a Claim** provision for *Claim Forms* in the **Claim Provisions** section of the certificate is amended so that claim forms will be sent to you within 10 working days from the date we receive the notice of a claim.

The **Claim Procedures** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim happens within 30 days after receipt of satisfactory Written Proof of Loss and benefits for which we are liable will be paid within 15 days after receipt of satisfactory Written Proof of Loss.

A **Payment of Interest** provision has been added to the **Claim Provisions** section of the certificate as follows:

> Any benefit payment issued after 30 days from the date we receive satisfactory Written Proof of Loss will accrue simple interest on the net benefit amount at the rate of 15% per year. Interest will accrue beginning on the day following the date that the benefit payment was due and ending on the date we make that benefit payment.
>
> For purposes of this provision, a benefit payment is considered paid on the date payment is mailed or transmitted electronically.

The **Overpayment of Claims** provision in the **Claim Provisions** section of the certificate is amended by limiting the right to recover overpayments to 365 days from the date the claim was paid. This provision reads as follows:

> We have the right to recover any overpayments made on a prior claim up to 365 days from the date the claim was paid. However, in the event that we have clear and documented proof of Fraud or other intentional misconduct, we have the right to recover any overpayments at any time. In any event, we will provide Written notice at least 30 days before we seek recovery of an overpayment. Written notice will include adequate information to identify the specific claim and the specific reason for the recovery.
>
> We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.
>
> We will not recover more money than the amount we paid you.

## For residents of Arkansas

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from active participation in a riot, insurrection, or terrorist activity. This exclusion is amended by removing "or terrorist activity".

The **Newborn Coverage Feature** provision in the **Hospital Indemnity Details** section of the certificate is amended as follows:

> **Newborn Coverage Feature**
> Your newborn or newly adopted Children will automatically be covered for 60 days from their Coverage Eligibility Date if you are insured.
>
> If you wish to continue Child coverage, you must notify us and pay any additional premium.
>
> If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Initial Enrollment** language in the **Enrolling for Coverage** provision in the **Start of Coverage** section of the certificate is amended for Children so that you can apply for their coverage within 90 days.

The **Initial Enrollment** language in the **Coverage Effective Date** provision in the **Start of Coverage** section of the certificate is amended for Children so that if coverage for a newly acquired Child is applied for within 90 days of the Child's Coverage Eligibility Date, coverage will begin on the Child's Coverage Eligibility Date, provided premiums are paid.

The **Children** definition in the **Glossary** section of the certificate is amended for a Child who is incapable of self-sustaining employment due to permanent intellectual or physical incapacity as follows:

> Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the Child's incapacity and dependency to us in order to continue coverage that would have otherwise ended due to age. Ongoing proof of incapacity and dependency must be provided, at our expense, when requested by us.

## For residents of Colorado

The **Exclusions** provision in the **Supplemental Health Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

## For residents of Idaho

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended as follows:

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- participation in a felony;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- activities required while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- elective procedures unless it is a result of congenital disease or anomaly of a covered dependent child
- cosmetic surgery, shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part, and reconstructive surgery because of a congenital disease or anomaly of a covered dependent child;
- procedures for weight loss or gender reassignment, unless deemed medically necessary;

- treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
- elective abortion for any reason other than to preserve the life of the female upon whom the abortion is performed;
- any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
- voluntary use of alcohol or drugs or treatment for alcoholism or drug addiction unless taken as prescribed or directed by the Insured's Physician; and
- Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
    - stroke, Alzheimer's disease, trauma, viral infection; or
    - other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Childbirth Limitation** provision in the **Hospital Indemnity** Details section of the certificate is amended so that Childbirth or Involuntary Complications of Pregnancy will be covered to the same extent as any other Covered Sickness.

The **Newborn Coverage Feature** provision in the **Hospital Details** section of the certificate is amended as follows:

**Newborn Coverage Feature**
Your newborn or newly adopted Children will automatically be covered for 60 days from the moment of live birth if you are insured.

Coverage will only continue if you notify us and enroll your Child for coverage on or before the end of the 60 day period. The appropriate premium (if any) must be received by us within 31 days of the date the monthly premium invoice is received by the Policyholder and a notice of premium (if any) is provided to the Employee.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Claim Procedures** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim happens immediately.

The **Childbirth** definition in the **Glossary** section of the certificate is amended as follows:

Birth of a child by routine vaginal delivery.

Childbirth or Involuntary Complications of Pregnancy will be treated as any other Covered Sickness.

A **Congenital Anomalies** definition has been added to the **Glossary** section of the certificate as follows:

Conditions existing at or from birth that are a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. Significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

The **Covered Sickness** definition in the **Glossary** section of the certificate is amended so that Childbirth or Involuntary Complications of Pregnancy will be treated as any other Covered Sickness.

An **Involuntary Complications of Pregnancy** definition has been added to the Glossary section of the certificate as follows:

Involuntary Complications of Pregnancy include, but are not limited to, the following:
- conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and

- Cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia.

The following are not involuntary complications of pregnancy: false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

**For residents of Indiana**

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid immediately or within 30 days after receipt of Written Proof of Loss.

The **Payments to a Minor or Incompetent Insured or Insured's Beneficiary of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that we can pay up to $5,000 to a minor or incompetent Insured or the Insured's Beneficiary.

The **Children** definition in the **Glossary** section of the certificate is amended as follows:

Any child from moment of birth to age 26 who is:
- your own natural offspring;
- your stepchild;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- any child subject to your legal guardianship; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

**For residents of Louisiana**

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution is amended so that if the Insured has not been adjudicated or convicted of a criminal offense, this exclusion would not apply.

The **Children** definition in the **Glossary** section of the certificate for "any other child residing with you through legal mandate that is dependent on you for financial support" is amended as follows:

- any other child, including grandchild, residing with you through legal mandate;

The **Children** definition in the **Glossary** section of the certificate is amended to include any other Child if placed following an execution of an act of voluntary surrender on the date on which the act of voluntary surrender becomes irrevocable.

## For residents of Minnesota

The state of **Minnesota** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Minnesota law. The minimum requirements of Minnesota law will apply to your claim.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not, is amended by removing the phrase, "or attempting or committing suicide".

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from:

- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;

is removed.

The **Newborn Coverage Feature** provision in the **Hospital Indemnity Details** section of the certificate is amended as follows:

**Newborn Coverage Feature**
Your newborn or newly adopted Children will automatically be covered from their Coverage Eligibility Date if you are insured.

If you do not have coverage for your Child at the time of birth or adoption, you must pay any required additional premium. If we do not receive premium for your newly eligible Child, we may reduce any benefits payable by the amount of the past due premiums applicable to the additional Child.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to pay any additional premium for the newly eligible Child.

## For residents of Montana

The state of **Montana** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Montana law. The minimum requirements of Montana law will apply to your claim.

The **Daily Stay** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to add the following:

We will pay an additional 50% of the amount shown in the Schedule of Benefits for Daily Stay due to Childbirth for each day the mother and newborn are in the Hospital, as long as the newborn Child is not receiving a benefit for Daily Stay.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from "being intoxicated" reads as follows:

- an Insured being voluntarily intoxicated;

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from "voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician;" reads as follows:

- an Insured's voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician;

The **Newborn Coverage Feature** provision in the **Hospital Indemnity Details** section of the certificate is amended as follows:

**Newborn Coverage Feature**
An Insured's newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Overpayment of Claims** provision in the **Claim Provisions** section of the certificate is amended by limiting the right to recover overpayments to 12 months from the date of payment. This provision reads as follows:

We have the right to recover any overpayments for up to 12 months due to:
- Fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

The 12 months we have to recover overpayments will begin:
- for Fraud, on the date the Department of Insurance (DOI) determines insufficient evidence of Fraud exists. If we suspect a claim is overpaid as the result of Fraud, we will report the activity and evidence to the DOI;
- for reasons other than Fraud, including error, omissions, misstatement, misrepresentation, or concealment of information, on the date we have actual knowledge of the invalid claim, overpayment, or other incorrect payment. We will not request reimbursement of an unpaid claim not the result of Fraud more than 24 months from the date of payment, regardless of the date we obtain actual knowledge of the invalid claim, overpayment, or other incorrect information.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments upon Written authorization from you.

We will not recover more money than the amount we paid you.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary.

The **Childbirth** definition in the **Glossary** section of the certificate is amended as follows:

Birth of a child by vaginal delivery or Cesarean section.

Childbirth will be treated as any other Covered Sickness.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

**For residents of New Hampshire**

The **Contestability** provision in the **Policy Provisions** section of the Policy is amended to remove reference to Fraud. Language has been replaced to read as follows:

> We can take legal or other action using statements made in signed applications by the Policyholder during the first two years after the Policy Effective Date. However, in the event of nonpayment of premium by the Insured or the Policyholder, we can take action at any time under the provision titled Cancellation of this Policy by Us and as permitted by applicable law.

The **Admission for Covered Accidents, Covered Sicknesses, or Childbirth** benefit in the **Hospital Indemnity Highlights** and **Hospital Indemnity Details** section of the certificate is amended to always include Childbirth.

The **Admission for Covered Accidents, Covered Sicknesses, or Childbirth - Hospital ICU** benefit in the **Hospital Indemnity Highlights** and **Hospital Indemnity Details** section of the certificate is amended to always include Childbirth.

The **Daily Stay** benefit in the **Hospital Indemnity Details** section of the certificate is amended to always include Childbirth.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended as follows:

> We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
> - participation in a felony;
> - injuring oneself intentionally or attempting or committing suicide, whether sane or not;
> - active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
> - participating in war or any act of war, whether declared or undeclared;
> - combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
> - elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
> - treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident; and
> - Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
>   - stroke, Alzheimer's disease, trauma, viral infection; or
>   - other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Appeal Procedures** provision in the **Claim Provisions** section of the certificate is amended to reflect that the appeals specialist is a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate or the supervisor of the person making the initial determination.

The **Time Limit on Certain Defenses** provision for *Contestability* in the **General Provisions** section of the certificate has been amended to remove reference to Fraud. Language has been replaced to read as follows:

> We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of nonpayment of an Insured's premium, we can take action at any time under the provision titled Cancellation of the Policy and this Certificate or Coverage and as permitted by applicable law.

The Assignment provision in the General Provisions section of the certificate is amended to reflect that in no event may an Insured's assignee be a healthcare provider.

The **Covered Sickness** definition in the **Glossary** section of the certificate is amended as follows:

> An illness, disease or medical condition, including pregnancy, which:
> - occurs on or after the Coverage Effective Date; and
> - occurs while coverage is in force.

The **Injury** definition in the **Glossary** section of the certificate is amended to read "Any damage or harm to the body."

The **Nurse** definition in the **Glossary** section of the certificate is amended to define a Nurse to include an Advanced Practice Registered Nurse, graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

**For residents of Ohio**

The **Admission for Covered Accidents, Covered Sicknesses, or Childbirth** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to add the following:

> We will pay an additional $100 for an Admission due to Childbirth for follow-up care either in a medical setting or through home health care visits.

The **Daily Stay** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to add the following:

> We will pay an additional 50% of the amount shown in the Schedule of Benefits for Daily Stay due to Childbirth for each day the mother and healthy newborn are in the Hospital, as long as the newborn Child is not receiving a benefit for Daily Stay.

The **Newborn Coverage Feature** provision in the **Hospital Indemnity Details** section of the certificate is amended as follows:

**Newborn Coverage Feature**
Your newborn, newly adopted, or Children placed for adoption will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid immediately or within 30 days after receipt of Written Proof of Loss.

The **Children** definition in the **Glossary** section of the certificate for "your lawfully adopted child as of the earliest of the date" is amended as follows:

- your lawfully adopted child as of the earliest of the date;
- the child is placed in your home or in a medical facility;
- you have initiated adoption proceedings;
- a petition is filed for you to adopt the child; or
- an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child.

**For residents of South Carolina**

The **Payments to a Minor or Incompetent Insured or Insured's Beneficiary of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that we can pay up to $5,000 to a minor or incompetent Insured or the Insured's Beneficiary.

**For residents of South Dakota**

The **Admission for Covered Accidents, Covered Sicknesses, or Childbirth** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to revise the following criteria for Hospital services that are not eligible for the purposes of this benefit:

For purposes of this benefit, the following Hospital services are not eligible:
- treatment in the Emergency Department;
- treatment on an Outpatient Basis; and
- any Confinement in an Observation Unit.

The **Daily Stay** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to revise the following criteria for Hospital services that are not eligible for the purposes of this benefit:

For purposes of this benefit, the following Hospital services are not eligible:
- treatment in the Emergency Department;
- treatment on an Outpatient Basis; and
- any Confinement in an Observation Unit.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended so that any claims caused by, contributed to by, or resulting from:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

are removed.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

The **Confined** or **Confinement** definition in the **Glossary** section of the certificate is amended as follows:

Assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, on the advice of a Physician.

The **Physician** definition in the **Glossary** section of the certificate is amended as follows:

A person performing tasks that are within the limits of his or her medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us. This exclusion does not apply in those areas in which the above mentioned person is the only Physician in the area and acting within the scope of their normal employment.

## For residents of Texas

The **Late Enrollment** paragraph of the **Enrolling for Coverage** provision in the **Start of Coverage** section of the certificate has been amended to add the following to read as follows:

**Special Enrollment for Children of Medical Support Order**
If you are not insured for coverage under this plan and later are required under a medical support order to provide group hospital indemnity coverage to your Child, you may enroll both you and your Child under this plan regardless of Enrollment Period restrictions. Your Child will automatically be enrolled for the first 31 days after we receive the receipt of the medical support order.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended as follows:

**Payment of Benefits**

Benefits for which we are liable will be paid within 60 days after we receive Written Proof of Loss. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits.
Benefits for Children who are receiving financial and medical benefits through the Texas Department of Human Services will be paid to the Texas Department of Human Services whenever:

- the Texas Department of Human Services is paying benefits pursuant to Chapters 31 and 32 of the Human Resources Code, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code;
- the parent who is covered by this certificate has possession or access to the Child pursuant to a court order, or is not entitled to access or possession of the Child and is required by the court to pay child support; and
- we are notified at the time of claim that the Child is receiving financial and medical assistance.

In addition, benefits for Children may also be paid to a possessory or managing conservator of the Child if the appointment for that Child was issued by a court in this or another state.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision or, if required, to the Texas Department of Human Services.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Representations in Applications** provision in the **General Provisions** section of the certificate is amended as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary. Statements may not be used in contesting the validity of the insurance with respect to which the statements were made after the insurance has been in force before the contest for a period of two years during the Insured's lifetime.

The **Contestability** provision in the **General Provisions** section of the certificate has been amended to remove reference to Fraud. The last sentence has been replaced to read as follows:

However, in the event of nonpayment of an Insured's premium, we can take action at any time under the provision titled Cancellation or Modification to the Policy and this Certificate of Coverage and as permitted by applicable law.

The **Fraud** provision in the **General Provisions** section of the certificate is amended as follows:

We want to make sure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

The **Children** definition in the **Glossary** section of the certificate for "any other child residing with you through legal mandate that is dependent on you for financial support" is amended as follows:

- any other child, including a grandchild, residing with you through legal mandate that is dependent on you for financial support; or

The **Children** definition in the **Glossary** section of the certificate is amended to include any other Child for whom you are required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state.

The **Nurse** definition in the **Glossary** section of the certificate is amended as follows:

A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us, unless they are the only Nurse in the area provided that they are acting within the scope of their practice.

The **Physician** definition in the **Glossary** section of the certificate is amended as follows:

A person performing tasks that are within the limits of his or her medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us, unless they are the only Physician in the area provided that they are acting within the scope of their practice.

**For residents of Utah**

The **Admission for Covered Accidents, Covered Sicknesses, or Childbirth** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to allow the Admission and Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Admission for Covered Accidents, Covered Sicknesses, or Childbirth - Hospital ICU** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to allow the Admission and Initial Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Daily Stay** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to allow the Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Daily Stay - Hospital ICU** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to allow the Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Short Stay** benefit in the **Hospital Indemnity Details** section of the certificate has been amended to allow the Short Stay within 180 days of the Covered Accident or as soon as reasonably possible.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from commission of or attempt to commit a felony; engaging in an illegal occupation or activity; or participation in a riot, insurrection, or terrorist activity is applied only if you were a voluntary participant.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from "being intoxicated" reads as follows:

- being intoxicated in violation of a law. For purposes of this exclusion, "intoxicated" means the Insured's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred;

The **Claim Procedures** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days.

The **Children** definition in the **Glossary** section of the certificate is amended as follows:

Any child from the moment of birth to the end of the month in which they reach age 26 who is:
- your own natural offspring;
- your stepchild;
- your lawfully adopted child as of the earliest of the date;
- the child is placed in your home or in a medical facility. If placement for adoption occurs within 30 days of the child's birth, coverage begins from the moment of birth. If placement for adoption occurs 30 days or more after the child's birth, coverage begins from the date of placement;
- a petition is filed for you to adopt the child; or
- an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; or
- any other child for whom you are required by court or administrative order to provide coverage for.

Coverage for your Child may be continued past the end of the month in which they reach age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

The **Hospital** definition in the **Glossary** section of the certificate has been amended as follows:

An institution licensed as a hospital and operating within the scope of its license and provides medically necessary hospital confinement or treatment for sick or injured people.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation or Subacute Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Nurse** definition in the **Glossary** section of the certificate has been amended to be defined as a healthcare professional trained, duly licensed, and operating within the scope of their license to care for people with Injuries or Sicknesses.

The **Physician** definition in the **Glossary** section of the certificate has been amended to be defined as a person performing tasks that are within the limits of his or her medical license.

**For residents of Vermont**

The state of **Vermont** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Vermont law. The minimum requirements of Vermont law will apply to your claim.

The minimum hours requirement of the **Eligible Groups** provision in the **Hospital Indemnity Highlights** section of the certificate is amended to cover eligible employees working at least 17.5 hours per week.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended so that any claims caused by, contributed to by, or resulting from:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

are removed.

The **Exclusions** provision in the **Hospital Indemnity Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from any Mental or Nervous Disorders is removed.

The **Autopsy** provision in the **Claim Provisions** section of the certificate is amended so that when we request an Autopsy where it is allowed by law, and not prohibited by the Insured's religion, it will be at our expense.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid immediately or within 30 days after receipt of Written Proof of Loss.

The **Fraud** provision in the **General Provisions** section of the certificate is amended as follows:

We want to make sure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

The **Covered Accident** definition in the **Glossary** section of the certificate is amended as follows:

A bodily Injury sustained by an Insured, which is the direct cause of the loss, independent of disease or bodily infirmity and which:
- occurs on or after the Coverage Effective Date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

The **Hospital** definition in the **Glossary** section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Hospital:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Mental or Nervous Disorders** definition in the **Glossary** section of the certificate is removed in its entirety.

The **Rehabilitation Unit** definition in the **Glossary** section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Rehabilitation Unit:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Subacute Rehabilitation Unit** definition in the **Glossary** section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Subacute Rehabilitation Unit:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Substance Abuse** definition in the **Glossary** section of the certificate is removed in its entirety.

## ERISA

### Additional Summary Plan Description Information

If the Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the summary plan description. The summary plan description and the Policy constitute the Plan. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information contained in this document.

**Name of Plan:**
Forest River, Inc. Plan

**Name and Address of Employer:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514

**Plan Identification Number:**
a. Employer IRS Identification #: 20-3284366
b. Plan #: 0

**Type of Welfare Plan:**
Hospital Indemnity

**Type of Administration:**
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

**ERISA Plan Year Ends:**
December 31

**Plan Administrator, Name, Address, and Telephone Number:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514
(534) 389-4600

Forest River, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

**Agent for Service of Legal Process on the Plan:**
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46514

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Insurance Company, 2211 Congress Street, Portland, Maine 04122, under 984569 013. Contributions to the Plan are made as stated under Paying for Coverage in the Certificate of Coverage.

**Employer's Right to Amend the Plan**
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying

policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in Writing and endorsed on or attached to the Plan.

**Employer's Right to Request Policy Change**

The Employer can request a Policy change. A change to the Policy will be made valid once approved by one of our officers. The change must be in Writing and endorsed on or attached to the Policy.

**Cancellation of the Policy by the Employer**

The Employer may cancel the Policy by providing us Written notice. In any event of cancellation, coverage will continue through the end of the day the cancellation takes effect.

A cancellation of the Policy will not affect a Payable Claim.

**Cancellation or Modification of the Policy by Us**

In addition, we may cancel or modify the Policy if the Policy terms are not met, the Employer fails to satisfy its obligations, premium is not paid, a change in the Employer or in the law impacts the benefits payable or the risks insured or, depending on the Policy, at our election after any rate guarantee period.

In any event, we will provide Written notice to the Employer prior to any cancellation or modification date. The Employer may cancel the Policy if it chooses not to accept the Policy modifications made by us.

A cancellation of the Policy will not affect a Payable Claim.

**Your Rights Under ERISA**

As a participant in the 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 the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon Written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps 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 pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's 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, if, for example, it finds your claim is frivolous.

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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

# Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

**COLLECTING INFORMATION**
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

**SHARING INFORMATION**
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

**SAFEGUARDING INFORMATION**
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

**ACCESS TO INFORMATION**
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

**CORRECTION OF INFORMATION**
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

**COVERAGE DECISIONS**
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

**CONTACTING US**
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

2020 Unum Group. All rights reserved. Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

unum.com MK-1883 (06-2020)

# NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

## Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

### Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

### Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

### Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

**The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**

# Welfare Benefit Plan

## Summary Plan Description

WRAP Plan

Forest River, Inc.
Welfare Benefit Plan

**Oferta de asistencia en idioma Español (Spanish Language Offer of Assistance).** Este documento del plan está escrito en inglés y contiene un resumen de sus derechos y beneficios bajo este plan de beneficios para empleados. Si tiene dificultades para comprender alguna parte de este documento, podemos brindarle ayuda. Comuníquese con Anna Pallen, su Representante de Recursos Humanos al 574-367-3317 (durante las horas normales de trabajo) o al apallen@forestriverinc.com para obtener ayuda.

# Forest River, Inc. Welfare Benefit Plan

## *Summary Plan Description*

Your Employer maintains the Forest River, Inc. Welfare Benefit Plan ("the Plan") for the exclusive benefit of, and to provide health and welfare benefits to its eligible employees and their eligible dependents.

This Summary Plan Description (SPD) summarizes the important features of the Plan, including your benefits and obligations under the Plan. Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. These benefits are provided under various insurance contracts, as well as through self-insured plans funded by the general assets of your Employer. The Benefit Documents for each Benefit are part of this SPD only to the extent it provides detailed descriptions regarding each Benefits' eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions. You should keep this SPD with the Benefit Documents provided to you upon enrollment in each Benefit. You should also share this SPD with any family members you have elected to cover under the Plan.

The Plan is required to comply with certain federal laws and regulations that may change with the passage of new or revised laws. Your Employer reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. Any amendment, termination or other action by your Employer will be done in accordance with its normal operating procedures and any applicable laws.

Certain terms in the SPD have special meaning and are capitalized throughout the SPD. Such terms are defined in more detail in the DEFINITIONS section of the SPD. If any information in this SPD conflicts with the terms of the official Plan Document, the terms of the Plan Document—not this SPD—will apply.

### Plan Contacts:

Below are the contacts you can reach out to for assistance regarding the Plan:

**Contact for Participant Questions about the Plan:**
HR
Forest River, Inc.
900 County Road 1
PO Box 3030
Elkhart, IN 46515
574-389-4600

**Contact for COBRA Coverage Notifications:**
COBRA Administrator
The Loomis Company
850 North Park Road
PO Box 7011
Wyomissing, PA 19810-6011
610-374-4040
cconte@loomisco.com

## TABLE OF CONTENTS


Plan Contacts: ..... i

**EMPLOYER INFORMATION** **1**

Who established the Plan? ..... 1

**PLAN INFORMATION** **1**

Amended and Restated Plan ..... 1

**ELIGIBILITY** **1**

Q1. Who is eligible for Benefits? ..... 1

Q2. Are my Dependents eligible to be covered by the Plan? ..... 1

Q3. How do I enroll in Benefits? ..... 1

Q4. Can I change Benefits throughout the year? ..... 1

Q5. When does coverage begin and end? ..... 2

Q6. What should I do if an Eligible Dependent loses eligibility status? ..... 2

**BENEFITS AND FUNDING** **2**

Q1. What is the purpose of the Plan? ..... 2

Q2. What is the Plan's funding method? ..... 2

Q3. What Benefits are provided by the Plan? ..... 2

Q4. What is the source of Contributions? ..... 2

Q5. How do I pay for Benefits? ..... 2

COORDINATION OF BENEFITS ..... 2

Q6. What happens if I am covered by two or more health plans? ..... 2

Q7. Will the Plan be primary or secondary payer if I am covered by Medicare? ..... 2

**CLAIMS AND APPEALS** **3**

Q1. What Claims and appeal procedures apply? ..... 3

Q2. How do I appeal a Claim or benefit determination? ..... 3

HEALTH CARE PLANS ..... 3

Q3. What types of Health Care Claims can I appeal? ..... 3

Q4. After I submit a Claim, when should I expect a response? ..... 3

Q5. If my Health Care Claim is denied, will I receive a notification? ..... 3

Q6. In addition to providing the notice of adverse benefit determination, is there anything else the Claims Administrator must do if a Health Care Claim is denied? ..... 4

Q7. If my Health Care Claim is denied, what should I do? ..... 4

Q8. Is there an expedited process for an urgent care Claim? ..... 4

Q9. If I appeal a Claim determination, what happens next? ..... 4

Q10. Will I receive a written notification of a claim determination on review (i.e., an appeal)? ..... 5

Q11. If my appeal is denied, do I have any other rights? ..... 5

DISABILITY PLANS ..... 5

Q12. When will I receive a Disability Claim determination? ..... 5

Q13. Will the Disability Claim determination period ever be extended? ..... 6

Q14. What if I did not submit all the necessary information to process my Disability Claim? ..... 6

Q15. Will I receive a notice if my Disability Claim is denied? ..... 6

Q16. If my Disability Claim is denied, what should I do? ..... 6

Q17. If I appeal a Disability Claim determination, what happens next? ..... 6

Q18. What if a Plan Component is not a Health Care or Disability Component? ..... 6

LEGAL ACTIONS ..... 6

**MISCELLANEOUS** **7**

LEAVE OF ABSENCE ..... 7

Q1. What happens to my Benefits if I take a leave of absence? ..... 7

Q2. Is my Employer required to comply with the Family and Medical Leave Act (FMLA)? ..... 7

Q3. What happens if my leave is protected by FMLA? 7
Q4. What happens if I experience a "change in status" while on FMLA leave? 7
Q5. What happens if I do not return to work following my FMLA leave? 7
Q6. What happens if my leave is protected under USERRA? 7
LEGAL MATTERS 7
Q7. Can I assign my rights under the Plan to another person or third party? 7
Q8. Is this document a contract between me and my Employer? 8

**DEFINITIONS 8**

**ADMINISTRATIVE INFORMATION 8**
Q1. Who has the authority to make determinations under the Plan? 8
Q2. What are some of the duties of the Plan Administrator? 8
Q3. Can changes be made to the Plan? 9
Q4. What happens if the Plan Administrator or its delegates makes a clerical error? 9
Q5. Who is responsible for the day-to-day operations of the Plan? 9
Q6. Who is responsible to administer the Plan's Claims? 9
Q7. How can I obtain additional information about the Plan? 9
Q8. If I receive a medical child support order, what should I do? 9
Q9. When can the Plan Administrator retroactively terminate coverage provided under a Health Care Plan? 9
Q10. What is considered fraud or intentional misrepresentation? 9

**YOUR RIGHTS UNDER ERISA 9**
Q1. Is the Plan subject to the Employee Retirement Income Security Act (ERISA)? 9
Q2. What are my legal rights and protections under the Plan? 9

**COBRA 10**
Q1. What is COBRA continuation coverage? 10
Q2. When is COBRA continuation coverage available? 11
Q3. How is COBRA continuation coverage provided? 11
Q4. Are there other coverage options besides COBRA continuation coverage? 12
Q5. Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? 12
Q6. What if I have additional questions? 12
Q7. How do I protect my COBRA rights? 12
Q8. What factors should be considered when determining to elect COBRA continuation coverage? 12
Q9. What is the procedure for obtaining COBRA continuation coverage? 12
Q10. What is the election period and how long must it last? 12
Q11. Will a waiver made before the end of the election period end a qualified beneficiary's election rights? 12
Q12. Is COBRA continuation coverage available if a qualified beneficiary has Medicare? 12
Q13. When may a qualified beneficiary's COBRA continuation coverage be terminated? 13
Q14. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? 13
Q15. What is considered timely when paying for COBRA continuation coverage? 13

**PRIVACY RIGHTS UNDER HIPAA 13**

**OTHER LEGAL NOTICES 14**
Q1. Do I have any other legal rights and protections under the Plan? 14

**APPENDIX A 17**
Plan Components and Claims Administrators 17

**APPENDIX B 19**
Eligibility and Participation Requirements 19

**APPENDIX C 21**

Premium Assistance under Medicaid and CHIP ..... 21

## EMPLOYER INFORMATION

### Who established the Plan?

The Plan Sponsor of the Plan is: Forest River, Inc.

Business Address: 900 County Road 1,
PO Box 3030
Elkhart, IN 46515

Business Telephone Number: 574-389-4600

Federal Tax Identification Number: 20-3284366

## PLAN INFORMATION

### Amended and Restated Plan

The official Name of the Plan is: Forest River, Inc. Welfare Benefit Plan

Plan Number: 510

Plan Year: January 1 through December 31 of the same calendar year.

The Plan originally took effect on: January 1, 2016.

This amended and restated SPD shall take effect on: January 1, 2025.

## ELIGIBILITY

### Q1. Who is eligible for Benefits?

You are generally eligible to participate in the Plan if you are a common-law employee of your Employer and meet the criteria provided in Appendix B.

### Q2. Are my Dependents eligible to be covered by the Plan?

Yes, Dependents can be covered by the Plan under certain Benefits.

If you elect coverage for your Dependent Child(ren), their coverage generally will end when they reach a Benefit's limiting age (e.g., age 26 for the Major Medical Option).

### Q3. How do I enroll in Benefits?

Once you meet the eligibility criteria described in Appendix B you may enroll in Benefits.

To enroll, follow the procedures below:

***Initial Enrollment***

If you are eligible to participate in the Plan for the first time, you must submit your elections and any supporting documents, if applicable, in a timely manner in accordance with your Employer's enrollment procedures. If you miss your enrollment period, you may have to wait until the next open enrollment period or experience a qualifying life event to enroll in the Plan.

***Annual Open Enrollment***

You may change your coverage (or elect coverage in the Plan if you did not elect coverage when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment materials on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year.

***Dependents***

Coverage of Dependents may be contingent on receiving required documents, as requested by the Plan Administrator. If applicable, and you fail to provide the required documents in a timely manner and you enroll a Dependent in coverage, the Dependent may be removed retroactively to the first date of eligibility.

### Q4. Can I change Benefits throughout the year?

Maybe. In order to pay your portion of Health Care Plan premiums on a pre-tax basis, the IRS limits election changes to the annual enrollment period UNLESS you experience one of the qualifying life events defined by the IRS, such as marriage, divorce, job change, birth, or adoption of a child, or when a dependent child reaches a Plan Component's limiting age. If you experience a qualifying life event you must notify the Plan Administrator within a specified timeframe following the event.

Any election made on an after-tax basis may be changed in accordance with the Employer's policy or applicable Plan Component limitations. In addition, HIPAA special enrollment rights allow you and your eligible Dependents to enroll in a Major Medical Plan Component if 1) you or your Dependents experience a loss of coverage under another group health plan, health insurance, Medicaid, or CHIP; 2) you gain a new Dependent

through marriage, birth, adoption, or placement for adoption; or 3) you or your Dependents become eligible for premium assistance through a state Medicaid or CHIP program.

### Q5. When does coverage begin and end?

Coverage begins on the date you meet any required waiting period and, depending on the Benefit, generally ends on the end of the month in which you cease to satisfy the eligibility requirements. See Appendix B for additional information on any applicable waiting period.

For example, coverage may end due to divorce, death, change in employment status (including termination), failure to pay Contributions, a Dependent Child reaching a Plan Component's limiting age, or a Plan amendment or termination. If you experience a divorce, you will not lose coverage, but your spouse will lose coverage. If your Dependent Child reaches a Plan Component's limiting age, you will not lose coverage, but your Child will lose coverage. If you experience a change in employment status that causes a change in Plan eligibility, you and your Dependents may lose coverage.

### Q6. What should I do if an Eligible Dependent loses eligibility status?

When one of your covered Dependents loses eligibility status, such as through death, divorce, or a Dependent Child reaching a Plan Component's limiting age, you will have 30 days after the event to make an election change to drop their coverage. In addition, a COBRA election will be available to your Dependent only if you notify your Employer in writing within 60 days after the later of (1) the date of the event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the event.

If you fail to notify the Plan Administrator when a Dependent becomes ineligible for coverage, you may be required to reimburse the Plan for costs incurred by the Plan and the Plan Administrator may take other action, as permitted by the Plan.

In general, a Dependent's coverage will terminate the date or end of the month in which your covered Dependent is no longer considered an eligible Dependent, as specified in the applicable Benefit Documents.

## BENEFITS AND FUNDING

### Q1. What is the purpose of the Plan?

The Plan is a welfare benefit plan that is intended to provide you with a range of Benefits to promote your health and welfare.

### Q2. What is the Plan's funding method?

Each Benefit offered under the Plan is funded through one of the following sources:

- Insurance contracts.
- Self-insured arrangements paid through the general assets of the Employer.

### Q3. What Benefits are provided by the Plan?

The Plan provides the Benefits listed on Appendix A to this SPD.

### Q4. What is the source of Contributions?

Depending on the Plan Component, the cost of your coverage is either paid by:

- Employer Contributions only; or,
- Employee Contributions only; or,
- Both Employer and employee Contributions.

### Q5. How do I pay for Benefits?

Depending on the Benefit, the cost of your coverage will be deducted from your pay on either a pre-tax or post-tax basis. Pre-tax payroll deductions lower your cost to participate in the Plan. Note that you do not pay Social Security taxes on the pre-tax dollars used, which could result in a small reduction in your Social Security benefits at retirement.

## COORDINATION OF BENEFITS

### Q6. What happens if I am covered by two or more health plans?

Coordination of benefits is governed by the Benefit Document applicable to each Benefit. In general, the Plan that covers you as an employee will be the primary payor with the other health plan covering any additional costs that may remain after the primary plan's benefits have been exhausted.

If your Dependent Children are covered by this Plan and your spouse's health plan, the health plans generally will perform coordination of benefits using the "birthday rule." This means if your birthday month occurs earlier in a calendar year than your spouse's birthday month, this Plan will be the primary payor.

### Q7. Will the Plan be primary or secondary payer if I am covered by Medicare?

If you are covered by Medicare, the Plan intends to pay either primary or secondary as follows.

- If you are 65 or older and your Employer has less than 20 employees, Medicare will be the primary payer.
- If you are 65 or older and your Employer has more than 20 employees, Medicare is the secondary payer.
- If you are disabled and your Employer has 100 or more employees, Medicare is the secondary payer.

- If you have End Stage Renal Disease (ESRD) and you are in the first 30 months of Medicare coverage, Medicare is the secondary payer during the 30-month coordination period.
- If you have ESRD and are covered by COBRA continuation coverage and you are in your first 30 months of Medicare coverage, Medicare is the secondary payer during the 30-month coordination period.
- If you are 65 or older and are covered by Medicare and COBRA continuation coverage, Medicare is the primary payer and COBRA is the secondary payer.
- If you are disabled and covered by Medicare and COBRA, Medicare is the primary payer and COBRA is the secondary payer.

## CLAIMS AND APPEALS

### Q1. What Claims and appeal procedures apply?

You must follow the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document. Notwithstanding the foregoing, in no event shall the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document provide fewer rights to you than the rights prescribed in Labor Regulation section 2560.503-1.

If the applicable Benefit Document does not include Claims and appeals procedures, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section and Section Four of the Plan document.

### Q2. How do I appeal a Claim or benefit determination?

If you disagree with a benefit or Claims determination, you must submit a written request to the Claims Administrator. Please see Appendix A for contact information, including the address of the Claims Administrator for the Benefit.

### HEALTH CARE PLANS

### Q3. What types of Health Care Claims can I appeal?

You can appeal any Claim for benefits, which includes a request for coverage determination, a pre-authorization or approval of a Plan benefit, or a utilization review determination in accordance with the terms of the Plan. Depending on the type of Claim, your Claim will fall into one of the following categories:

- ***Urgent Care Claims*** – Claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that could cause severe pain.
- ***Pre-Service Claims*** – Claims that require notification or approval prior to receiving medical care.
- ***Concurrent Care Claims*** – Claims that were previously approved for treatment.
- ***Post-Service Claims*** – Claims that are filed for payment of benefits after medical care has been received.

### Q4. After I submit a Claim, when should I expect a response?

The timeframe for a Plan Component to provide notice of a Claim determination varies based on the type of Claim filed:

| CLAIM TYPE | DEADLINE FOR MAKING INITIAL DETERMINATION |
|---|---|
| **Urgent care** | As soon as possible, and no later than **72 hours** after receiving the Claim |
| **Pre-service** | Within a reasonable time period, and no later than **15 days** after receiving the Claim* |
| **Post-service** | Within a reasonable time period, and no later than **30 days** after receiving the Claim* |

For concurrent medical care Claims, if the treatment was previously approved, the request to extend the treatment will be processed within 24 hours of the receipt of the request if the request is made 24 hours prior to the end of the approved treatment. However, if the request is not made at least 24 hours prior to the end of the approved treatment, the request will be processed as an urgent care Claim.

***Extension of Claim Determination Deadline***

- **Urgent Care Claims**. If the Plan Component needs more information, it must tell the Claimant within 24 hours and give the Claimant at least 48 hours to respond. Then the plan must decide the Claim within 48 hours after receiving the missing information or within 48 hours of the deadline for the Claimant to supply the missing information, whichever comes first.
- **Pre-Service Claims and Post-Service Claims**. The Plan Component may extend the time period up to 15 days more if, for reasons beyond its control, the plan cannot make the decision within the first deadline. If the Plan Component requests more information, the Claimant has at least 45 days to supply it. The Plan Component then must decide the Claim within 15 days after receiving the additional information or within 15 days of the deadline for the Claimant to supply the additional information, whichever comes first.

### Q5. If my Health Care Claim is denied, will I receive a notification?

Yes, if your Claim is denied in full or in part, you will receive a written notice of adverse benefit determination. The notice will contain the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.

- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either a) an explanation of the scientific or clinical judgment for the determination, or b) a statement that such explanation will be provided free of charge, upon request.
- If the denial involves an urgent care Claim, the notice will also include a description of the expedited review process applicable to such Claims.

## Q6. In addition to providing the notice of adverse benefit determination, is there anything else the Claims Administrator must do if a Health Care Claim is denied?

Yes, the Claims Administrator is required to take the following steps:

- Ensure that any notice includes information sufficient to identify the Claim, including the date of service, the health care provider, and the amount of the Claim. Moreover, the Plan must provide notice of the opportunity to request the diagnosis code, the treatment code, and its corresponding meaning;
- Ensure the notice includes the denial code and its corresponding meaning and the standard used to deny the Claim;
- Provide a description of the internal appeal and external review processes available under the Plan;
- Provide a description of how to initiate an appeal; and
- Disclose the availability of any applicable office of health insurance consumer assistance or ombudsman available to assist with internal Claims and appeals or external review processes, including contact information.

## Q7. If my Health Care Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The Claims Administrator will review the appeal upon receipt and will follow the terms of the Plan. An appeal decision will be made within the time frame provided by the Plan and will be reviewed even if information or documents are missing from the appeal.

A document, record, or other information is relevant to a Claim if it

- was relied upon in making the Claim determination;
- was submitted, considered, or generated in the course of making the Claim determination, even if it was not used to make the Claim determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim reviews follow the terms of the Plan has been applied consistently; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by you relating to the Claim, even if the information was not submitted or considered in the initial Claim review. The review will not rely on the initial denial and will be performed by a fiduciary of the Plan who is neither the individual who denied the Claim nor a direct report of that individual.

## Q8. Is there an expedited process for an urgent care Claim?

Yes, you are entitled to an expedited review process that permits you to submit your request orally or in writing and that permits all necessary information to be shared by telephone, facsimile, or other similarly expeditious method.

## Q9. If I appeal a Claim determination, what happens next?

***First Appeal***

Once you have submitted an appeal, you will receive a written response, as follows:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal by the Plan Component.

- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal by the Plan Component.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan Component**.**
- **Concurrent Care Claim.** Before treatment ends or is reduced, where the adverse determination is the decision to reduce or terminate concurrent care early, or, if the Component Plan denies your request to extend treatment, within the appropriate time period based upon the type of Claim.

***Second Appeal***

If specified in the Benefit Documents for each Plan Component or in documentation given to you by the Claims Administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

The appeal decision with respect to any second appeal will be made according to the following schedule:

- **Urgent Care Claim**. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- **Concurrent Claim**. The response will be made in the appropriate time period based upon the type of Claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

## Q10. Will I receive a written notification of a claim determination on review (i.e., an appeal)?

Yes, you will receive a final notice of adverse benefit determination. The notice will include the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why the material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to the procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, or (ii) a statement that such explanation will be provided free of charge, upon request.
- 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."

## Q11. If my appeal is denied, do I have any other rights?

Yes, you may have the right to request an independent, external review. Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

## DISABILITY PLANS

## Q12. When will I receive a Disability Claim determination?

You will receive a written or electronic notification of the Plan's Claim decision within 45 days.

### Q13. Will the Disability Claim determination period ever be extended?

Yes, the Plan may extend the review period twice, each time by 30 days, if the extension is necessary due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan will notify you in writing.

### Q14. What if I did not submit all the necessary information to process my Disability Claim?

The Plan will send you a written notice and will provide a description of the required documents or information. You will then have 45 days to submit the additional information to the Plan.

### Q15. Will I receive a notice if my Disability Claim is denied?

Yes, you will receive a notice that will contain the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.

### Q16. If my Disability Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

### Q17. If I appeal a Disability Claim determination, what happens next?

Once you have submitted an appeal, you will receive a written response within 45 days after receipt of your request to review a Claim determination. The 45-day period may be extended by 45 days if the Plan determines that special circumstances require an extension. If an extension is required, you will receive a written notification.

## NON-HEALTH/NON-DISABILITY PLANS

### Q18. What if a Plan Component is not a Health Care or Disability Component?

Generally, any Plan Component that is not a Health Care or Disability Component will review a Claim within 90 days and provide written notification of its decision. The 90-day period may be extended by 90-days in certain circumstances. If you disagree with the Claim decision, you may file an appeal within 60 days of your receipt of the written notice of denial of a Claim. The Plan administrator will then render a decision within 60 days after receipt of the request for review. In special circumstances, the Plan may make a determination within 120 days after the receipt of your request for review. If such an extension is required, you will be notified in writing.

## LEGAL ACTIONS

### Q19. What should I do if I want to pursue a legal action against the Plan?

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this SPD or, if applicable, the Benefit Documents of a Plan Component, you may lose the right to file suit in state or federal court in the state of Indiana.

The individual named below can be served with legal papers regarding the Plan.

Forest River, Inc.
Attn: David Besinger, Vice President of Human Resources
900 County Road 1,
PO Box 3030
Elkhart, IN 46515

Service of legal process also may be directed to the Plan Administrator.

### Q20. What is the time limit to bring a lawsuit?

Please refer to the applicable Benefit Document for information about the time period applicable to your Claim. If the Benefit Document does not contain any such provision, as permitted by law, you must bring a lawsuit within the following time frames:

- In the case of a Plan Component that is self-insured by your Employer, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Plan Component, the time period for bringing any lawsuit against the insurance company issuing such Plan Component or the Plan will be determined by the terms of the applicable Plan Component. If the Plan Component does not set forth such a time period, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits must be brought within one year of the act or omission giving rise to the claim.

## MISCELLANEOUS

### LEAVE OF ABSENCE

### Q1. What happens to my Benefits if I take a leave of absence?

Depending on the leave policies and procedures adopted by your Employer, you may be able to continue certain Benefits while on an approved leave of absence. If you are eligible to continue certain Benefits, you may be required to complete certain forms or documents and pay towards the cost of coverage.

### Q2. Is my Employer required to comply with the Family and Medical Leave Act (FMLA)?

Yes, your Employer is required to comply with FMLA. The Plan Administrator must continue Health Care Plan coverage while you are on leave protected by the FMLA.

### Q3. What happens if my leave is protected by FMLA?

If your leave is protected under FMLA, you may continue your group health care coverage under the Plan (e.g. Medical, Dental, or Vision) for you and any covered Dependents as long as you continue to pay your portion of the cost for your Benefits during the leave, or if allowed, after the leave.

Your Employer may offer the following options for payment of Contributions:

- ***Paid Leave*** – Contributions will be automatically deducted from payroll.
- ***Unpaid Leave*** – You will be required to submit payment to your Employer for any required Contributions. If you do not pay Contributions in a timely manner, your Employer has at least 15 days before cessation of your coverage to provide you with a notice of the cancellation. Unless your Employer has adopted a longer grace period, you will have **15 days** from the date of the notice to make the required payment. If you fail to make the payment in the permitted time, your coverage will be cancelled.

Any coverage that is terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required Contributions, including any catch-up payments, if applicable, attributable to the period prior to your return from leave.

### Q4. What happens if I experience a "change in status" while on FMLA leave?

If you experience a "change in status" (e.g., change in marital status, number of Dependents, residency, or employment status), you may change your coverage election as if you were actively employed.

### Q5. What happens if I do not return to work following my FMLA leave?

If you do not return to work following your FMLA leave, you may be entitled to COBRA continuation coverage, if applicable. You may also be required to reimburse your Employer for costs of coverage provided to you while you were on unpaid FMLA leave.

### Q6. What happens if my leave is protected under USERRA?

If you are going into or returning from military service, your Benefits may be protected under USERRA. Under USERRA, you may elect to continue coverage under the Plan for up to 24 months. To continue coverage, you must comply with the terms of the Plan, including election and payment of coverage. Moreover, upon return from leave protected under USERRA, your coverage will be reinstated (i.e., begin again).

### LEGAL MATTERS

### Q7. Can I assign my rights under the Plan to another person or third party?

Except as otherwise specifically provided in the Plan or required by law, Benefits payable to you or your Dependents under the Plan may not be assigned, transferred or in any way made over to another party.

Even if an assignment is permitted under the Benefit Document, the Plan Administrator, or any delegated third-party, has the right to determine the validity of the assignment.

### Q8. Is this document a contract between me and my Employer?

No, this document is an SPD and is intended to summarize general provisions of the Plan. This document does not constitute a contract of any type between you and your Employer. Nothing in this document shall give you any right of employment.

## DEFINITIONS

When used in this SPD with initial capital letters, the following words will have the meanings described below unless the content indicates other meanings are intended. If any defined term in this SPD conflicts with the same term contained in an insurance contract or other document, the other document shall govern.

**BENEFIT** – Each benefit available under the Plan, as identified in Appendix A.

**BENEFIT DOCUMENT** – Any policy, contract, or other document that governs the terms of the Benefit.

**CHILD(REN)** – Your child(ren) as defined in a Benefit Document.

**CLAIM** – A request for benefits made by you under the terms of the Benefit Document.

**CLAIMS ADMINISTRATOR** – The Plan Administrator or the third party appointed by the Plan Administrator to review claims submitted by you, including appeals, as applicable.

**CONTRIBUTIONS** – The amount paid by you or your Employer equal to the cost of coverage under a Benefit.

**DEPENDENT** – Your dependent as defined in the applicable Benefit Document.

**DISABILITY PLAN** – The Benefit that provides a Participant supplemental income during a limited or extended period of time due to the inability to work as a result of illness, injury, or accident. The Disability Plan includes a short-term disability plan, other than state-mandated benefits, and a long-term disability plan.

**EMPLOYER** – Your Employer who adopted this Plan is Forest River, Inc. Your Employer will also serve as the Plan Administrator, as defined in the Employee Retirement Income Security Act (ERISA), who is responsible for the day-to-day operations and decisions regarding the Plan, unless a separate Plan Administrator is appointed for all or some of the Plan responsibilities.

**HEALTH CARE PLAN** – Any Benefit that provides medical care, including a Major Medical Option, dental, vision, or an employee assistance program.

**MAJOR MEDICAL OPTION** – A Benefit that provides medical benefits, other than vision or dental benefits, to eligible employees and their Eligible Dependents.

**PARTICIPANT** – An employee of your Employer who has satisfied the eligibility requirements and entered the Plan.

**PLAN** – The Plan described in this SPD is the Forest River, Inc. Welfare Benefit Plan.

**PLAN ADMINISTRATOR** – Your Employer is responsible for the day-to-day administration of the Plan and is the Plan Administrator unless an appointed Plan Administrator is named in the Administrative Information section of this SPD.

**PLAN DOCUMENT** – The document that sets out the official terms and conditions of the Plan.

**PLAN SPONSOR** – The Plan Sponsor is Forest River, Inc.

## ADMINISTRATIVE INFORMATION

### Q1. Who has the authority to make determinations under the Plan?

The Plan Administrator has discretionary authority to interpret and make determinations under the Plan. The Plan Administrator may delegate its authority to third parties regarding Claims administration (e.g., the review and processing of Claims), ministerial services (e.g., recordkeeping, mailing of notices, etc.), and other services, as necessary.

### Q2. What are some of the duties of the Plan Administrator?

The Plan Administrator's duties include, but are not limited to, the following:

- Appointing and supervising a third-party administrator to pay Claims;
- Administering the Plan in accordance with its terms;
- Delegating to any person or entity powers, duties, and responsibilities, as necessary;
- Determining all questions of eligibility, status, and coverage under the Plan;
- Interpreting the Plan, including ambiguities, inconsistencies, omissions, and disputed terms;
- Making factual findings;
- Deciding disputes that may arise relative to a covered person's rights;
- Recommending procedures for filing a Claim for Benefits, review Claim denials, and appeals relating to them, and uphold or reverse such denials;
- Keeping and maintaining the Plan document and all other records pertaining to the Plan;
- Performing all necessary reporting, as required by ERISA, if applicable;
- Establishing and communicating procedures to determine an order's status as a qualified medical child support order; and

- Performing functions necessary for the Plan's administration.

### Q3. Can changes be made to the Plan?

Yes. While the Employer intends to maintain the Plan indefinitely, the Employer may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending Benefits provided under the Plan. If an amendment, suspension, or termination is enacted, the Employer will provide notice, as required by law.

### Q4. What happens if the Plan Administrator or its delegates makes a clerical error?

If the Plan Administrator or its delegated agent make a clerical error, the error will not invalidate coverage. Rather, coverage effective dates will be determined solely in accordance with the provisions of the Plan, including any Benefit Document. Moreover, as permitted by law, the Plan Administrator will make an equitable adjustment as a result of an error or delay.

### Q5. Who is responsible for the day-to-day operations of the Plan?

Your Employer is responsible for the Plan's day-to-day administration.

To assist in operating the Plan efficiently and accurately, your Employer may appoint additional persons or organizations to act on its behalf or to perform certain functions. The Plan Administrator may provide the Claims administration through a third-party Claims Administrator.

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Plan Administrator has the exclusive right to interpret the Plan's provisions. You may contact the Plan Administrator for any further information about the Plan.

### Q6. Who is responsible to administer the Plan's Claims?

The Claims Administrator is responsible to administer the Plan's Claims. The Claims Administrator is:

- The Insurance Issuer or self-insured plan administrator appointed by the Employer.
- The Employer.

Refer to the chart in Appendix A for Claims Administrator contact information.

### Q7. How can I obtain additional information about the Plan?

For additional information regarding the Plan, contact the person or department listed on Page i of this SPD, or refer to the Benefit Documents. Copies of the Plan document, this SPD, and incorporated Benefit Documents are available free of charge from your Employer upon request.

### Q8. If I receive a medical child support order, what should I do?

If you receive a medical child support order, send the order to the Plan Administrator. The Plan Administrator will then review the order to determine if it is a "qualified medical child support order" (QMCSO). If it is determined the order is a QMCSO, the Plan will automatically change your coverage to extend coverage to the Child. Coverage for the Child will begin on the date specified in the order, or if none is specified, the date of the order, as permitted under a Benefit.

You are permitted to obtain, without charge, a copy of the policy and/or procedures governing the QMCSO from the Plan Administrator.

### Q9. When can the Plan Administrator retroactively terminate coverage provided under a Health Care Plan?

A retroactive termination of coverage is referred to as a "rescission." The Plan Administrator may retroactively terminate your coverage or the coverage of your Eligible Dependent if you commit fraud or if you intentionally misrepresent a material fact to the Plan.

### Q10. What is considered fraud or intentional misrepresentation?

Fraud or intentional misrepresentation occurs when you obtain Benefits by fraudulently or intentionally misrepresenting a material fact to the Plan. If you fraudulently or intentionally misrepresent a fact, the Plan Administrator may take certain action, as permitted by law, at its sole discretion.

## YOUR RIGHTS UNDER ERISA

### Q1. Is the Plan subject to the Employee Retirement Income Security Act (ERISA)?

Yes, the Plan is subject to ERISA and you have certain rights summarized in this section.

### Q2. What are my legal rights and protections under the Plan?

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to the following.

***Receive Information About Your Plan and Benefits***

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (if required by ERISA to be prepared) and updated SPD. The administrator may charge a reasonable fee for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary Annual Report.

***Continue Health Care Plan Coverage***
The Plan Administrator is required to continue Health Care Plan coverage for you or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing your COBRA continuation coverage rights.

***Prudent Actions by Plan Fiduciaries***
In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, 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 benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within a certain period of time. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document 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 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 Plan Administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's Claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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, 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.

***Assistance With Your Questions***
If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## COBRA

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this SPD or contact the Plan Administrator.

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

### Q1. What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this Q1. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Each qualified beneficiary is required to pay the entire cost of COBRA coverage, including both employee and employer contributions. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the Health Care Plan.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

## Q2. When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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 coverage.

***NOTICE PROCEDURES:***

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days, or a longer time period if permitted by the Plan, or the latest of:**

- The date of the qualifying event;
- The date coverage would be lost because of the qualifying event; or
- The date on which the qualified beneficiary was informed of the responsibility to provide the notice and procedures for doing so.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must include:

- the Plan's name: Forest River, Inc. Welfare Benefit Plan,
- the name and address of the Participant and any other qualified beneficiaries;
- the Qualifying Event and the date it happened, and,
- be accompanied by any documentation providing proof of the event (e.g., the divorce decree, legal separation agreement).

If provided electronically (if allowed), your notice should be provided by following the Plan Administrator's reasonable procedures established in compliance with the regulations.

**You must provide this notice to the person, department or entity listed on Page i of this SPD.**

## Q3. How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

***Disability extension of 18-month period of COBRA continuation coverage***

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

To qualify for the disability extension, the qualified beneficiary must notify the Plan Administrator of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures described above.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation

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

### Q4. Are there other coverage options besides COBRA continuation coverage?

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

### Q5. Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

### Q6. What if I have additional questions?

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

### Q7. How do I protect my COBRA rights?

***Keep Your Plan Administrator Informed of Address Changes***. To protect your family's rights, you should keep the Plan Administrator informed of any changes in your family members' addresses. You should also keep a copy, for your records, of any notices that you send to the Plan Administrator or its designee.

### Q8. What factors should be considered when determining to elect COBRA continuation coverage?

You may have the right to request special enrollment in another health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends because of a Qualifying Event listed above. You may also have the same special right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

### Q9. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

### Q10. What is the election period and how long must it last?

The election period is the time period within which the qualified beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of 1) the date the qualified beneficiary would lose coverage because of the Qualifying Event, or 2) the date notice is provided to the qualified beneficiary of the qualified beneficiary's right to elect COBRA continuation coverage.

### Q11. Will a waiver made before the end of the election period end a qualified beneficiary's election rights?

If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. The waiver's revocation is an election of COBRA continuation coverage. If a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

### Q12. Is COBRA continuation coverage available if a qualified beneficiary has Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are entitled to Medicare benefits on or before the date on which COBRA continuation coverage is elected. But a qualified beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare or becomes covered under another health Plan.

## Q13. When may a qualified beneficiary's COBRA continuation coverage be terminated?

A qualified beneficiary may waive COBRA continuation coverage during the election period. Except for an interruption of coverage in connection with a waiver, a qualified beneficiary's COBRA continuation coverage must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates.

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the qualified beneficiary.
- The date upon which your Employer ceases to provide any health Plan (including a successor Plan) to any employee.
- The date, after the date of the election, that the qualified beneficiary first becomes covered under a health Plan.
- The date, after the date of the election, that the qualified beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- The later of the following two dates if the qualified beneficiary is entitled to a disability extension.

    1. The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

    2. The earlier of 1) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled, or 2) 29 months after the date of the Qualifying Event.

The Plan can terminate for cause a qualified beneficiary's coverage on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries (for example, for submitting a fraudulent Claim).

If the Plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, and an individual who is not a qualified beneficiary receives coverage under the Plan solely because of the individual's relationship to a qualified beneficiary, the Plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

## Q14. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

## Q15. What is considered timely when paying for COBRA continuation coverage?

Payment is made timely if made no later than 30 days after the first day of the coverage period.

The Plan does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to those providing COBRA continuation coverage.

If you make a timely payment and the payment is less than the amount the Plan requires, the Plan Administrator may consider the amount timely if 1) the amount owed is insignificant, and 2) you pay the amount owed within a reasonable period. A reasonable period is 30 days, and an insignificant amount is considered $50 or 10% of the required amount. Please see the Plan document for additional information.

# PRIVACY RIGHTS UNDER HIPAA

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice describes how your Protected Health Information (PHI) may be used or disclosed under the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PHI or Electronic Protected Health Information (ePHI) means individually identifiable health information held by, or on behalf of, the Plan.

***Uses and Disclosures of Your Information***

The Plan Administrator on behalf of the Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan—including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your Claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and Claims management purposes. Note that the Genetic Information Nondiscrimination Act (GINA) prohibits using PHI that is genetic information for underwriting purposes. In addition, the Plan may disclose your PHI to the Plan Administrator so that the Plan Administrator can perform administrative functions on behalf of the Plan, such as facilitating Claims or appeals.

The Plan also may use or disclose your PHI where required or permitted by law. The Plan Administrator on behalf of the Plan is permitted to use or disclose PHI:

- when required by law;
- for public health activities;
- to report Child or domestic abuse;
- for governmental oversight activities;
- pursuant to judicial or administrative proceedings;
- for certain law enforcement purposes;
- for a coroner, medical examiner, or funeral director in order to obtain information about a deceased individual;
- for organ, eye, or tissue donation purposes;
- for certain government-approved research activities;
- to avert a serious threat to an individual's or the public's health or safety;
- for certain government functions, such as related to military service or national security;

- to comply with workers' compensation laws;
- to a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- to notify a family member or other individual involved in the care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

For any other uses and disclosures of your PHI, the Plan will obtain your written authorization. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes. You may revoke this authorization in writing at any time, provided the Plan has not yet acted while relying on your authorization.

Stricter State Privacy Laws – Under the HIPAA privacy and security rules, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

***Your Rights With Respect To Your Health Information***
You have several rights with respect to your PHI, which are described below. Please contact your Employer's Privacy Officer if you have questions about your rights.

- You have the right to request restrictions on how your PHI may be used or disclosed. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.
- You have the right to receive your PHI confidentially, such as at a location other than your home, if you state in writing that disclosing the information through normal means could endanger you.
- You have the right to inspect and copy your PHI that is maintained by the Plan in a designated record set or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies.
- You have the right to request an amendment to your PHI that the Plan maintains in a designated record set. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.
- You have a right to request an accounting of disclosures that the Plan has made of your PHI during the six years before your request, except for disclosures that you have authorized or for disclosures related to routine treatment, payment, or health care operations of the Plan.
- You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

***Our Duties With Respect To Your Individually Identifiable Health Information***
The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices with respect to your PHI.

***Questions?***
If you have questions or would like more information about the Plan's privacy policies, you may contact the Privacy Officer. The Privacy Officer is responsible for developing and implementing the Plan's privacy policies and procedures.

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing such a complaint.

## OTHER LEGAL NOTICES

### Q1. Do I have any other legal rights and protections under the Plan?

Yes, the Plan is required to comply with other federal regulations, which guarantee certain legal rights and protections, as follows.

***Your Rights Under the Patient Protection and Affordable Care Act***
The Patient Protection and Affordable Care Act (PPACA or ACA) provides certain consumer protections, including the elimination of annual and lifetime limits on benefits, the provision of preventive services without cost sharing, the limitation of out-of-pocket annual costs, the coverage of essential health benefits, the elimination of waiting periods of more than 90 days for coverage to begin, the elimination of pre-existing conditions, and the guarantee of issue and renewal of coverage. As applicable, these provisions are contained within the Benefit Document of the Major Medical Option.

***Your Rights Under the Americans With Disabilities Act***
The Americans with Disabilities Act (ADA) provides that your Employer may not discriminate against you on the basis of disability. In addition, it generally restricts your Employer from obtaining medical information from you but permits your Employer to obtain medical information or request medical examinations as part of a voluntary Wellness Program. Your Employer may not deny you the right to access the Wellness Program on the basis of disability. If you have a disability, your Employer is required to provide a reasonable accommodation or adjustment that allows you to participate in the Wellness Program. Any information provided to your Employer due to participation in the Wellness Program must remain confidential. To request an accommodation, please contact the Plan Administrator or follow the instructions contained in the "Notice Regarding Wellness Program."

***Your Rights Under the Family and Medical Leave Act***
The Family and Medical Leave Act (FMLA) provides that Health Care must be maintained during any period of unpaid leave covered by FMLA under the same conditions as if you continued to work. Moreover, FMLA requires that you be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA. If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse your Employer for its share of health care premiums or Contributions paid on your behalf during your FMLA leave.

***Your Rights Under the Genetic Information Nondiscrimination Act of 2008***
The Genetic Information Nondiscrimination Act of 2008 (GINA) provides that your Employer may not discriminate against you on the basis of genetic information, including adjusting premiums and contribution amounts.

***Your Rights Under the Health Insurance Portability and Accountability Act (Special Enrollment)***
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain special enrollment rights if you decline coverage in the Major Medical Option for yourself or your Eligible Dependents because of other coverage. If you or your Eligible Dependents lose eligibility for that other coverage or if your Employer stops contributing toward your or your Dependent's other coverage, you may be able to enroll yourself and your Eligible Dependent in the Major Medical Option. Generally, you must request enrollment within 30 days after your or your Eligible Dependent' other coverage ends or after your Employer stops contributing toward the other coverage.

If the other coverage is Medicaid or the Children's Health Insurance Program (CHIP), you must request enrollment within 60 days after you or your Eligible Dependents' Medicaid or CHIP coverage ends. Finally, if you have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

***Your Rights Under the Health Insurance Portability and Accountability Act (Health Factors)***
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the Major Medical Option from discriminating against you or your Eligible Dependents based on a health factor. Health factors include your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. Compliance with this provision is not determinative of compliance with any other federal or state laws, including COBRA or ADA.

***Your Rights Under the Mental Health Parity and Addiction Equity Act of 2008***
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provides that if any Major Medical Option under the Plan 1) provides for both medical and surgical benefits and mental health or substance use disorder benefits, and 2) is not subject to increased cost exemption (within the meaning of the MHPAEA), the following conditions apply:

- The Major Medical Option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Major Medical Option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential Participant upon request.
- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant will, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the Participant in accordance with the Claims procedures applicable to the group medical coverage feature.
- The Plan will be operated and constructed in all respects in compliance with the MHPAEA.

"Mental health benefits" and "substance use disorder benefits" are defined in the Major Medical Option applicable to the health insurance option, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.

***Your Rights Under Michelle's Law***
Michelle's Law provides that a Major Medical Option of the Plan that requires a certification of student status for any period of coverage of an Eligible Dependent will comply with Public Law No. 110-381 (2008), as amended from time to time. Eligibility for such coverage for an Eligible Dependent who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the Eligible Dependent to lose eligibility for coverage under any Major Medical Option's coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the medically necessary leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier.

***Your Rights Under Newborns' and Mothers' Health Protection Act***
The Newborns' and Mothers' Health Protection Act (NMHPA) provides that the Major Medical Option of the Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Major Medical Option may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

***Your Maternity Hospital Stay Rights under Indiana State Law***
Every group insurance policy issued in the State of Indiana that provides maternity benefits must provide minimum benefits to a mother and her newborn child that cover a minimum length of postpartum stay at a hospital that is consistent with the minimum postpartum hospital stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. If the patient's attending physician determines further inpatient care is not necessary for the mother or newborn child, a policy or group contract that provides maternity benefits may provide under the policy or group contract a shorter length of postpartum hospital stay than under the guidelines, but the policy or contract must authorize for the mother and the newborn one at-home postdelivery care visit not later than 48 hours following the discharge of the woman and her newborn child from a licensed hospital. However, at the mother's discretion, the visit may occur at the facility of the provider subject to the terms of the policy or group contract.

***Your Rights Under Title VII of the Civil Rights Act of 1964***
Generally, benefits provided under a group health plan must be provided without regard to the race, color, sex (including pregnancy), national origin, or religion of the eligible employee and his or her eligible dependents. A group health plan cannot discriminate on the basis of: eligibility to receive coverage under the Plan; the terms and conditions on which coverage is provided; or, what an employee is charged for coverage.

In addition, under the Pregnancy Discrimination Act of 1978, group health plans must provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as coverage for nonpregnancy-related conditions.

***Your Rights Under USERRA***
The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of Health Care Plan coverage if you are called for active-duty military service. The maximum length of extended coverage under USERRA is the lesser of

- 24 months beginning on the date that the military leave begins, or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional two-percent administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the U.S. Department of Veterans Affairs) incurred as a result of the military service.

***Your Rights Under Women's Health and Cancer Rights Act***
The Women's Health and Cancer Rights Act (WHCRA) requires that a Major Medical Option that provides medical and surgical benefits with respect to a mastectomy provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, copays, and coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable medical option. Please refer to the Major Medical Option's summary of benefits coverage for additional information. If you have other questions, please contact the Plan Administrator.

***Your Rights Under Consolidated Appropriations Act 2021***
The Consolidated Appropriations Act 2021 (CAA) provides for:

- Certain disclosures, including insurance ID cards with stated in-network and out-of-network deductibles and out-of-pocket costs; and provider directories that are current and accurate.
- Notification of the ability to receive transitional care for an ongoing course of treatment when an in-network facility transitions to an out-of-network facility during a course of treatment.
- Protections from surprise medical bills from out-of-network providers for emergency services and out-of-network services at in-network facilities.

Contact your Plan Administrator for this information as it pertains to a particular Benefit.

# Appendix A
# Forest River, Inc. Welfare Benefit Plan

## Plan Components and Claims Administrators

Benefit Documents are part of this SPD. Any update to the Benefit Document will replace any earlier versions for the period defined in the updated Benefit Document.

| Fully-Insured Benefits | Policy/Group No. | Type of Benefit | Claims Administrator<br>*(Use the address & phone number on your ID Card if different)* | |
|---|---|---|---|---|
| **Paramount Dental**<br>100 Madison Avenue<br>Toledo, OH 43604 | 379280325020<br>379283275020<br>379290555020<br>379290565020 | Dental – PPO | Paramount<br>PO Box 928<br>Toledo, OH 43697-0928 | 800-727-1444<br>www.insuringsmiles.com |
| **Provident Life and Accident Insurance Co/Unum**<br>One Fountain Square<br>Chattanooga, TN 37402 | 155183<br>132692 | Individual Disability Insurance (IDI) | Unum Benefits Center<br>PO Box 100158<br>Columbia, SC 29202-3158 | 888-226-7959<br>www.unum.com/employees/file-a-claim |
| **Transamerica Life Insurance Company**<br>4333 Edgewood Road Northeast<br>Cedar Rapids, IA 52499 | G000046683 | Voluntary Term Life | Transamerica<br>PO Box 219<br>Cedar Rapids, IA 52406-0219 | 888-763-7474<br>tebcustresp@transamerica.com<br>www.transamerica.com/portal/claims-materials |
| **Unum Life Insurance Company of America**<br>1 Fountain Square<br>Chattanooga, TN 37402<br>*(Voluntary Worksite Effective January 1, 2026)* | 951841 | Basic Life/AD&D (with EAP)<br>Voluntary Life/AD&D | Unum Benefits Center<br>PO Box 100158<br>Columbia, SC 29202-3158 | Life: 800-445-0402<br>Disability: 800-858-6843<br>EAP: www.unum.com/employees/file-a-claim<br>Worksite: 800-635-5597<br>www.unum.com/employees/file-a-claim |
| | 951839 | Short-Term Disability | | |
| | 951840 | Long-Term Disability | | |
| | 984567 | Voluntary Accident | | |
| | 984568 | Voluntary Critical Illness | | |
| | 984569 | Voluntary Hospital Indemnity | | |
| **Vision Service Plan (VSP)**<br>3333 Quality Drive<br>Rancho Cordova, CA 95670 | 30068748 | Vision | *In-Network:*<br>VSP<br>PO Box 495907<br>Cincinnati, OH 45249-5907<br>*Out-of-Network:*<br>VSP<br>PO Box 495918<br>Cincinnati, OH 45249-5918 | 800-877-7195<br>www.vsp.com/faqs/claims-reimbursement |
| **Voya/Reliastar Life Insurance Company**<br>20 Washington Avenue South<br>Minneapolis, MN 55401<br>*(Terminated Effective December 31, 2025)* | 71143-8 | Voluntary Worksite Benefits (Accident, Critical Illness, Hospital Indemnity) | Voya Claims<br>PO Box 320<br>Minneapolis, MN 55440 | 877-236-7564<br>www.voya.com/claims |

| Self-Insured Benefits | Contract No. | Type of Benefit | Claims Administrator<br>*(Use the address & phone number on your ID Card if different)* | |
|---|---|---|---|---|
| **Allied Benefit Systems, Inc.**<br>200 West Adams Street, Suite 500<br>Chicago, IL 60606 | A22100 | Medical – PPO | Allied<br>PO Box 909786-60690<br>Chicago, IL 60690 | 800-288-2078<br>www.alliedbenefit.com |
| **CapitalRx**<br>1 World Trade Center<br>New York, NY 10007 | JD145 | Prescription Drugs | CapitalRx<br>9450 SW Gemini Drive, Suite 87234<br>Beaverton, OR 97008 | 888-832-2779<br>www.cap-rx.com |

**Non-ERISA Benefits** In addition to the above Component Plans, eligible employees are offered non-ERISA welfare benefits. Such non-ERISA benefits are not governed by ERISA and include the following benefit plan(s):

| Issuer/Provider | Type of Non-ERISA Benefit |
|---|---|
| **Metropolitan Life Insurance Company (MetLife)** | Identity Theft Protection |

# Appendix B
# Forest River, Inc. Welfare Benefit Plan

## Eligibility and Participation Requirements

*An employee who is determined to be benefit-eligible as of his or her start date shall be able to participate in the Plan as of the Coverage Date specified below.*

| Employee Class | Working Hours Minimum | Benefits Offered | Date Coverage Begins |
|---|---|---|---|
| Key Executive Employees | 20 hours per week | All Benefits Included in Appendix A | First day of the month coinciding with or following two months of employment |
| Salary Employees | 20 hours per week | All Benefits Included in Appendix A except IDI | |
| Hourly Employees | 20 hours per week | All Benefits Included in Appendix A except LTD and IDI | |
| Part-Time Employees | Working some weekly hours at least 75% of the time (39 weeks out of 52) | Medical | |

***Dependent Eligibility***

Unless specified otherwise under the applicable Plan Component's benefit documents, coverage for dependents, if elected, begins on the date the Employee's coverage begins (provided the Employee timely enrolls them in coverage). Mid-Plan Year elections for newly acquired Dependents may also be permitted under certain circumstances.

Dependent Definitions. For purposes of eligibility and participation in this Plan, Dependent definitions shall have the same meaning set forth in each applicable Plan Component's benefit documents, or if not defined in the applicable Plan Component documents, in accordance with the policies adopted by the Employer.

Proof of Dependent Status. Your Employer reserves the right to verify a Dependent is eligible or continues to be eligible for coverage under the Plan. Documents requested may include (but are not limited to) copies of birth certificates, court orders, divorce decrees or marriage certificates as needed to establish dependent status. Dependent eligibility determinations made by your Employer shall be final, binding and conclusive on all parties claiming an interest in the Plan.

Dual Coverage Prohibited. Except as specifically provided otherwise in an applicable Plan Component's Benefit Documents, in no event will an employee be covered under a Plan Component as both a participant and a dependent, or a dependent be covered under a Plan Component as a dependent of more than one participant.

***Rehire Rule***

Unless otherwise specified to the contrary in the Benefit Documents for a Component Plan, an employee who is rehired prior to the end of a 13-consecutive week period of time after date of termination will be credited with hours of service met towards the eligibility waiting period during his or her preceding period of employment. Otherwise, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and participation requirements for his or her employment class.

***Special Eligibility Rules for Variable Hour, Part-Time, and Seasonal Employees***

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status ("ACAFT") under special eligibility rules for variable hour, part-time, and seasonal employees. In the event your Employer adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

For purposes of these special eligibility rules (known as either the "Look-Back Measurement Method" or "Monthly Measurement Method"), a variable hour, part-time or seasonal employee will achieve ACA-FT status after averaging 130 or more hours of service per month (or 30 or more hours of service per week) during a period of time spanning a specific number of consecutive months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the "Stability Period." The maximum length of any Measurement Period or Stability Period shall not exceed 12-consecutive months.

If applicable, details regarding the Look-Back Measurement Method and/or Monthly Measurement Method adopted by your Employer (e.g. the classes of employees it applies to, a description of each type of measurement period, breaks-in-services rules, and procedures used to count hours of service) are available upon request from the Plan Administrator.

***Cessation of Participation***

Unless otherwise stated in the applicable Benefit Documents, your coverage will cease upon the earliest of the following:

- The date or end of the month (as applicable under each Plan Component) in which you cease to satisfy the eligibility requirements for a particular Plan Benefit. This may result from your death, reduction in hours, or termination of active employment, or if your hours of service are tracked under the ACA Look-Back Measurement Method, it may result because you lose ACA full-time status during a subsequent Standard Stability Period;
- The end of the period for which you paid your required Contribution if the Contribution for the next period is not paid when due;
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") as described in the "Your Rights Under USERRA" section; or,

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the contract or agreement, or by discontinuance of Contributions for your Employer.

Coverage for your spouse and other Dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Documents for the Plan Components. In addition, their coverage will terminate:

- The date or end of the month on which your covered spouse or Child is no longer considered an eligible Dependent;
- The date, end of the month, or end of the Plan Year in which your Dependent Child attains a Plan Component's limiting age (unless the Plan Component allows for the continuation of coverage for a mentally or physically disabled Child who is primarily dependent on you for support);
- The end of the pay period in which you stop making Contributions required for Dependent coverage; or,
- The date that a Child is no longer covered under QMCSO, if the Child is not otherwise eligible to participate in the Plan.

Depending on the reason for termination of coverage, you and your covered Dependents may have the right to continue health coverage temporarily under COBRA. See the "COBRA" section of this SPD for details.

# APPENDIX C
# Forest River, Inc. Welfare Benefit Plan

## Premium Assistance under Medicaid and CHIP

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Medicaid and CHIP+** | **FLORIDA – Medicaid** |
| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **GEORGIA – Medicaid** | **INDIANA – Medicaid** |
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: (678) 564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |

| KENTUCKY – Medicaid | LOUISIANA – Medicaid |
|---|---|
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: -800-977-6740.<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/health-care-coverage/<br>Phone: 1-800-657-3672 | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311<br>(Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |

| TEXAS – Medicaid | UTAH – Medicaid and CHIP |
|---|---|
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website: https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP<br>(1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

# Welfare Benefit Plan

## Summary Plan Description

WRAP Plan

Forest River, Inc.
Welfare Benefit Plan

**Oferta de asistencia en idioma Español (Spanish Language Offer of Assistance).** Este documento del plan está escrito en inglés y contiene un resumen de sus derechos y beneficios bajo este plan de beneficios para empleados. Si tiene dificultades para comprender alguna parte de este documento, podemos brindarle ayuda. Comuníquese con Anna Pallen, su Representante de Recursos Humanos al 574-367-3317 (durante las horas normales de trabajo) o al apallen@forestriverinc.com para obtener ayuda.

# Forest River, Inc. Welfare Benefit Plan

## *Summary Plan Description*

Your Employer maintains the Forest River, Inc. Welfare Benefit Plan ("the Plan") for the exclusive benefit of, and to provide health and welfare benefits to its eligible employees and their eligible dependents.

This Summary Plan Description (SPD) summarizes the important features of the Plan, including your benefits and obligations under the Plan. Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. These benefits are provided under various insurance contracts, as well as through self-insured plans funded by the general assets of your Employer. The Benefit Documents for each Benefit are part of this SPD only to the extent it provides detailed descriptions regarding each Benefits' eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions. You should keep this SPD with the Benefit Documents provided to you upon enrollment in each Benefit. You should also share this SPD with any family members you have elected to cover under the Plan.

The Plan is required to comply with certain federal laws and regulations that may change with the passage of new or revised laws. Your Employer reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. Any amendment, termination or other action by your Employer will be done in accordance with its normal operating procedures and any applicable laws.

Certain terms in the SPD have special meaning and are capitalized throughout the SPD. Such terms are defined in more detail in the DEFINITIONS section of the SPD. If any information in this SPD conflicts with the terms of the official Plan Document, the terms of the Plan Document—not this SPD—will apply.

### Plan Contacts:

Below are the contacts you can reach out to for assistance regarding the Plan:

**Contact for Participant Questions about the Plan:**
HR
Forest River, Inc.
900 County Road 1
PO Box 3030
Elkhart, IN 46515
574-389-4600

**Contact for COBRA Coverage Notifications:**
COBRA Administrator
The Loomis Company
850 North Park Road
PO Box 7011
Wyomissing, PA 19810-6011
610-374-4040
cconte@loomisco.com

## TABLE OF CONTENTS


Plan Contacts: ..... i

**EMPLOYER INFORMATION** **1**

Who established the Plan? ..... 1

**PLAN INFORMATION** **1**

Amended and Restated Plan ..... 1

**ELIGIBILITY** **1**

Q1. Who is eligible for Benefits? ..... 1

Q2. Are my Dependents eligible to be covered by the Plan? ..... 1

Q3. How do I enroll in Benefits? ..... 1

Q4. Can I change Benefits throughout the year? ..... 1

Q5. When does coverage begin and end? ..... 2

Q6. What should I do if an Eligible Dependent loses eligibility status? ..... 2

**BENEFITS AND FUNDING** **2**

Q1. What is the purpose of the Plan? ..... 2

Q2. What is the Plan's funding method? ..... 2

Q3. What Benefits are provided by the Plan? ..... 2

Q4. What is the source of Contributions? ..... 2

Q5. How do I pay for Benefits? ..... 2

COORDINATION OF BENEFITS ..... 2

Q6. What happens if I am covered by two or more health plans? ..... 2

Q7. Will the Plan be primary or secondary payer if I am covered by Medicare? ..... 2

**CLAIMS AND APPEALS** **3**

Q1. What Claims and appeal procedures apply? ..... 3

Q2. How do I appeal a Claim or benefit determination? ..... 3

HEALTH CARE PLANS ..... 3

Q3. What types of Health Care Claims can I appeal? ..... 3

Q4. After I submit a Claim, when should I expect a response? ..... 3

Q5. If my Health Care Claim is denied, will I receive a notification? ..... 3

Q6. In addition to providing the notice of adverse benefit determination, is there anything else the Claims Administrator must do if a Health Care Claim is denied? ..... 4

Q7. If my Health Care Claim is denied, what should I do? ..... 4

Q8. Is there an expedited process for an urgent care Claim? ..... 4

Q9. If I appeal a Claim determination, what happens next? ..... 4

Q10. Will I receive a written notification of a claim determination on review (i.e., an appeal)? ..... 5

Q11. If my appeal is denied, do I have any other rights? ..... 5

DISABILITY PLANS ..... 5

Q12. When will I receive a Disability Claim determination? ..... 5

Q13. Will the Disability Claim determination period ever be extended? ..... 6

Q14. What if I did not submit all the necessary information to process my Disability Claim? ..... 6

Q15. Will I receive a notice if my Disability Claim is denied? ..... 6

Q16. If my Disability Claim is denied, what should I do? ..... 6

Q17. If I appeal a Disability Claim determination, what happens next? ..... 6

Q18. What if a Plan Component is not a Health Care or Disability Component? ..... 6

LEGAL ACTIONS ..... 6

**MISCELLANEOUS** **7**

LEAVE OF ABSENCE ..... 7

Q1. What happens to my Benefits if I take a leave of absence? ..... 7

Q2. Is my Employer required to comply with the Family and Medical Leave Act (FMLA)? ..... 7

Q3. What happens if my leave is protected by FMLA? 7
Q4. What happens if I experience a "change in status" while on FMLA leave? 7
Q5. What happens if I do not return to work following my FMLA leave? 7
Q6. What happens if my leave is protected under USERRA? 7
LEGAL MATTERS 7
Q7. Can I assign my rights under the Plan to another person or third party? 7
Q8. Is this document a contract between me and my Employer? 8

**DEFINITIONS 8**

**ADMINISTRATIVE INFORMATION 8**
Q1. Who has the authority to make determinations under the Plan? 8
Q2. What are some of the duties of the Plan Administrator? 8
Q3. Can changes be made to the Plan? 9
Q4. What happens if the Plan Administrator or its delegates makes a clerical error? 9
Q5. Who is responsible for the day-to-day operations of the Plan? 9
Q6. Who is responsible to administer the Plan's Claims? 9
Q7. How can I obtain additional information about the Plan? 9
Q8. If I receive a medical child support order, what should I do? 9
Q9. When can the Plan Administrator retroactively terminate coverage provided under a Health Care Plan? 9
Q10. What is considered fraud or intentional misrepresentation? 9

**YOUR RIGHTS UNDER ERISA 9**
Q1. Is the Plan subject to the Employee Retirement Income Security Act (ERISA)? 9
Q2. What are my legal rights and protections under the Plan? 9

**COBRA 10**
Q1. What is COBRA continuation coverage? 10
Q2. When is COBRA continuation coverage available? 11
Q3. How is COBRA continuation coverage provided? 11
Q4. Are there other coverage options besides COBRA continuation coverage? 12
Q5. Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? 12
Q6. What if I have additional questions? 12
Q7. How do I protect my COBRA rights? 12
Q8. What factors should be considered when determining to elect COBRA continuation coverage? 12
Q9. What is the procedure for obtaining COBRA continuation coverage? 12
Q10. What is the election period and how long must it last? 12
Q11. Will a waiver made before the end of the election period end a qualified beneficiary's election rights? 12
Q12. Is COBRA continuation coverage available if a qualified beneficiary has Medicare? 12
Q13. When may a qualified beneficiary's COBRA continuation coverage be terminated? 13
Q14. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? 13
Q15. What is considered timely when paying for COBRA continuation coverage? 13

**PRIVACY RIGHTS UNDER HIPAA 13**

**OTHER LEGAL NOTICES 14**
Q1. Do I have any other legal rights and protections under the Plan? 14

**APPENDIX A 17**
Plan Components and Claims Administrators 17

**APPENDIX B 19**
Eligibility and Participation Requirements 19

**APPENDIX C 21**

Premium Assistance under Medicaid and CHIP ..... 21

## EMPLOYER INFORMATION

### Who established the Plan?

The Plan Sponsor of the Plan is: Forest River, Inc.

Business Address: 900 County Road 1,
PO Box 3030
Elkhart, IN 46515

Business Telephone Number: 574-389-4600

Federal Tax Identification Number: 20-3284366

## PLAN INFORMATION

### Amended and Restated Plan

The official Name of the Plan is: Forest River, Inc. Welfare Benefit Plan

Plan Number: 510

Plan Year: January 1 through December 31 of the same calendar year.

The Plan originally took effect on: January 1, 2016.

This amended and restated SPD shall take effect on: January 1, 2025.

## ELIGIBILITY

### Q1. Who is eligible for Benefits?

You are generally eligible to participate in the Plan if you are a common-law employee of your Employer and meet the criteria provided in Appendix B.

### Q2. Are my Dependents eligible to be covered by the Plan?

Yes, Dependents can be covered by the Plan under certain Benefits.

If you elect coverage for your Dependent Child(ren), their coverage generally will end when they reach a Benefit's limiting age (e.g., age 26 for the Major Medical Option).

### Q3. How do I enroll in Benefits?

Once you meet the eligibility criteria described in Appendix B you may enroll in Benefits.

To enroll, follow the procedures below:

***Initial Enrollment***

If you are eligible to participate in the Plan for the first time, you must submit your elections and any supporting documents, if applicable, in a timely manner in accordance with your Employer's enrollment procedures. If you miss your enrollment period, you may have to wait until the next open enrollment period or experience a qualifying life event to enroll in the Plan.

***Annual Open Enrollment***

You may change your coverage (or elect coverage in the Plan if you did not elect coverage when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment materials on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year.

***Dependents***

Coverage of Dependents may be contingent on receiving required documents, as requested by the Plan Administrator. If applicable, and you fail to provide the required documents in a timely manner and you enroll a Dependent in coverage, the Dependent may be removed retroactively to the first date of eligibility.

### Q4. Can I change Benefits throughout the year?

Maybe. In order to pay your portion of Health Care Plan premiums on a pre-tax basis, the IRS limits election changes to the annual enrollment period UNLESS you experience one of the qualifying life events defined by the IRS, such as marriage, divorce, job change, birth, or adoption of a child, or when a dependent child reaches a Plan Component's limiting age. If you experience a qualifying life event you must notify the Plan Administrator within a specified timeframe following the event.

Any election made on an after-tax basis may be changed in accordance with the Employer's policy or applicable Plan Component limitations. In addition, HIPAA special enrollment rights allow you and your eligible Dependents to enroll in a Major Medical Plan Component if 1) you or your Dependents experience a loss of coverage under another group health plan, health insurance, Medicaid, or CHIP; 2) you gain a new Dependent

through marriage, birth, adoption, or placement for adoption; or 3) you or your Dependents become eligible for premium assistance through a state Medicaid or CHIP program.

### Q5. When does coverage begin and end?

Coverage begins on the date you meet any required waiting period and, depending on the Benefit, generally ends on the end of the month in which you cease to satisfy the eligibility requirements. See Appendix B for additional information on any applicable waiting period.

For example, coverage may end due to divorce, death, change in employment status (including termination), failure to pay Contributions, a Dependent Child reaching a Plan Component's limiting age, or a Plan amendment or termination. If you experience a divorce, you will not lose coverage, but your spouse will lose coverage. If your Dependent Child reaches a Plan Component's limiting age, you will not lose coverage, but your Child will lose coverage. If you experience a change in employment status that causes a change in Plan eligibility, you and your Dependents may lose coverage.

### Q6. What should I do if an Eligible Dependent loses eligibility status?

When one of your covered Dependents loses eligibility status, such as through death, divorce, or a Dependent Child reaching a Plan Component's limiting age, you will have 30 days after the event to make an election change to drop their coverage. In addition, a COBRA election will be available to your Dependent only if you notify your Employer in writing within 60 days after the later of (1) the date of the event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the event.

If you fail to notify the Plan Administrator when a Dependent becomes ineligible for coverage, you may be required to reimburse the Plan for costs incurred by the Plan and the Plan Administrator may take other action, as permitted by the Plan.

In general, a Dependent's coverage will terminate the date or end of the month in which your covered Dependent is no longer considered an eligible Dependent, as specified in the applicable Benefit Documents.

## BENEFITS AND FUNDING

### Q1. What is the purpose of the Plan?

The Plan is a welfare benefit plan that is intended to provide you with a range of Benefits to promote your health and welfare.

### Q2. What is the Plan's funding method?

Each Benefit offered under the Plan is funded through one of the following sources:

- Insurance contracts.
- Self-insured arrangements paid through the general assets of the Employer.

### Q3. What Benefits are provided by the Plan?

The Plan provides the Benefits listed on Appendix A to this SPD.

### Q4. What is the source of Contributions?

Depending on the Plan Component, the cost of your coverage is either paid by:

- Employer Contributions only; or,
- Employee Contributions only; or,
- Both Employer and employee Contributions.

### Q5. How do I pay for Benefits?

Depending on the Benefit, the cost of your coverage will be deducted from your pay on either a pre-tax or post-tax basis. Pre-tax payroll deductions lower your cost to participate in the Plan. Note that you do not pay Social Security taxes on the pre-tax dollars used, which could result in a small reduction in your Social Security benefits at retirement.

## COORDINATION OF BENEFITS

### Q6. What happens if I am covered by two or more health plans?

Coordination of benefits is governed by the Benefit Document applicable to each Benefit. In general, the Plan that covers you as an employee will be the primary payor with the other health plan covering any additional costs that may remain after the primary plan's benefits have been exhausted.

If your Dependent Children are covered by this Plan and your spouse's health plan, the health plans generally will perform coordination of benefits using the "birthday rule." This means if your birthday month occurs earlier in a calendar year than your spouse's birthday month, this Plan will be the primary payor.

### Q7. Will the Plan be primary or secondary payer if I am covered by Medicare?

If you are covered by Medicare, the Plan intends to pay either primary or secondary as follows.

- If you are 65 or older and your Employer has less than 20 employees, Medicare will be the primary payer.
- If you are 65 or older and your Employer has more than 20 employees, Medicare is the secondary payer.
- If you are disabled and your Employer has 100 or more employees, Medicare is the secondary payer.

- If you have End Stage Renal Disease (ESRD) and you are in the first 30 months of Medicare coverage, Medicare is the secondary payer during the 30-month coordination period.
- If you have ESRD and are covered by COBRA continuation coverage and you are in your first 30 months of Medicare coverage, Medicare is the secondary payer during the 30-month coordination period.
- If you are 65 or older and are covered by Medicare and COBRA continuation coverage, Medicare is the primary payer and COBRA is the secondary payer.
- If you are disabled and covered by Medicare and COBRA, Medicare is the primary payer and COBRA is the secondary payer.

## CLAIMS AND APPEALS

### Q1. What Claims and appeal procedures apply?

You must follow the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document. Notwithstanding the foregoing, in no event shall the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document provide fewer rights to you than the rights prescribed in Labor Regulation section 2560.503-1.

If the applicable Benefit Document does not include Claims and appeals procedures, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section and Section Four of the Plan document.

### Q2. How do I appeal a Claim or benefit determination?

If you disagree with a benefit or Claims determination, you must submit a written request to the Claims Administrator. Please see Appendix A for contact information, including the address of the Claims Administrator for the Benefit.

### HEALTH CARE PLANS

### Q3. What types of Health Care Claims can I appeal?

You can appeal any Claim for benefits, which includes a request for coverage determination, a pre-authorization or approval of a Plan benefit, or a utilization review determination in accordance with the terms of the Plan. Depending on the type of Claim, your Claim will fall into one of the following categories:

- ***Urgent Care Claims*** – Claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that could cause severe pain.
- ***Pre-Service Claims*** – Claims that require notification or approval prior to receiving medical care.
- ***Concurrent Care Claims*** – Claims that were previously approved for treatment.
- ***Post-Service Claims*** – Claims that are filed for payment of benefits after medical care has been received.

### Q4. After I submit a Claim, when should I expect a response?

The timeframe for a Plan Component to provide notice of a Claim determination varies based on the type of Claim filed:

| CLAIM TYPE | DEADLINE FOR MAKING INITIAL DETERMINATION |
|---|---|
| **Urgent care** | As soon as possible, and no later than **72 hours** after receiving the Claim |
| **Pre-service** | Within a reasonable time period, and no later than **15 days** after receiving the Claim* |
| **Post-service** | Within a reasonable time period, and no later than **30 days** after receiving the Claim* |

For concurrent medical care Claims, if the treatment was previously approved, the request to extend the treatment will be processed within 24 hours of the receipt of the request if the request is made 24 hours prior to the end of the approved treatment. However, if the request is not made at least 24 hours prior to the end of the approved treatment, the request will be processed as an urgent care Claim.

***Extension of Claim Determination Deadline***

- **Urgent Care Claims**. If the Plan Component needs more information, it must tell the Claimant within 24 hours and give the Claimant at least 48 hours to respond. Then the plan must decide the Claim within 48 hours after receiving the missing information or within 48 hours of the deadline for the Claimant to supply the missing information, whichever comes first.
- **Pre-Service Claims and Post-Service Claims**. The Plan Component may extend the time period up to 15 days more if, for reasons beyond its control, the plan cannot make the decision within the first deadline. If the Plan Component requests more information, the Claimant has at least 45 days to supply it. The Plan Component then must decide the Claim within 15 days after receiving the additional information or within 15 days of the deadline for the Claimant to supply the additional information, whichever comes first.

### Q5. If my Health Care Claim is denied, will I receive a notification?

Yes, if your Claim is denied in full or in part, you will receive a written notice of adverse benefit determination. The notice will contain the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.

- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either a) an explanation of the scientific or clinical judgment for the determination, or b) a statement that such explanation will be provided free of charge, upon request.
- If the denial involves an urgent care Claim, the notice will also include a description of the expedited review process applicable to such Claims.

## Q6. In addition to providing the notice of adverse benefit determination, is there anything else the Claims Administrator must do if a Health Care Claim is denied?

Yes, the Claims Administrator is required to take the following steps:

- Ensure that any notice includes information sufficient to identify the Claim, including the date of service, the health care provider, and the amount of the Claim. Moreover, the Plan must provide notice of the opportunity to request the diagnosis code, the treatment code, and its corresponding meaning;
- Ensure the notice includes the denial code and its corresponding meaning and the standard used to deny the Claim;
- Provide a description of the internal appeal and external review processes available under the Plan;
- Provide a description of how to initiate an appeal; and
- Disclose the availability of any applicable office of health insurance consumer assistance or ombudsman available to assist with internal Claims and appeals or external review processes, including contact information.

## Q7. If my Health Care Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The Claims Administrator will review the appeal upon receipt and will follow the terms of the Plan. An appeal decision will be made within the time frame provided by the Plan and will be reviewed even if information or documents are missing from the appeal.

A document, record, or other information is relevant to a Claim if it

- was relied upon in making the Claim determination;
- was submitted, considered, or generated in the course of making the Claim determination, even if it was not used to make the Claim determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim reviews follow the terms of the Plan has been applied consistently; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by you relating to the Claim, even if the information was not submitted or considered in the initial Claim review. The review will not rely on the initial denial and will be performed by a fiduciary of the Plan who is neither the individual who denied the Claim nor a direct report of that individual.

## Q8. Is there an expedited process for an urgent care Claim?

Yes, you are entitled to an expedited review process that permits you to submit your request orally or in writing and that permits all necessary information to be shared by telephone, facsimile, or other similarly expeditious method.

## Q9. If I appeal a Claim determination, what happens next?

***First Appeal***

Once you have submitted an appeal, you will receive a written response, as follows:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal by the Plan Component.

- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal by the Plan Component.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan Component**.**
- **Concurrent Care Claim.** Before treatment ends or is reduced, where the adverse determination is the decision to reduce or terminate concurrent care early, or, if the Component Plan denies your request to extend treatment, within the appropriate time period based upon the type of Claim.

***Second Appeal***

If specified in the Benefit Documents for each Plan Component or in documentation given to you by the Claims Administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

The appeal decision with respect to any second appeal will be made according to the following schedule:

- **Urgent Care Claim**. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- **Concurrent Claim**. The response will be made in the appropriate time period based upon the type of Claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

## Q10. Will I receive a written notification of a claim determination on review (i.e., an appeal)?

Yes, you will receive a final notice of adverse benefit determination. The notice will include the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why the material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to the procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, or (ii) a statement that such explanation will be provided free of charge, upon request.
- 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."

## Q11. If my appeal is denied, do I have any other rights?

Yes, you may have the right to request an independent, external review. Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

## DISABILITY PLANS

## Q12. When will I receive a Disability Claim determination?

You will receive a written or electronic notification of the Plan's Claim decision within 45 days.

### Q13. Will the Disability Claim determination period ever be extended?

Yes, the Plan may extend the review period twice, each time by 30 days, if the extension is necessary due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan will notify you in writing.

### Q14. What if I did not submit all the necessary information to process my Disability Claim?

The Plan will send you a written notice and will provide a description of the required documents or information. You will then have 45 days to submit the additional information to the Plan.

### Q15. Will I receive a notice if my Disability Claim is denied?

Yes, you will receive a notice that will contain the following information:

- Information sufficient to identify the Claim.
- The specific reason for the denial.
- Reference to the specific Plan provisions on which the denial was based.
- A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.

### Q16. If my Disability Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

### Q17. If I appeal a Disability Claim determination, what happens next?

Once you have submitted an appeal, you will receive a written response within 45 days after receipt of your request to review a Claim determination. The 45-day period may be extended by 45 days if the Plan determines that special circumstances require an extension. If an extension is required, you will receive a written notification.

## NON-HEALTH/NON-DISABILITY PLANS

### Q18. What if a Plan Component is not a Health Care or Disability Component?

Generally, any Plan Component that is not a Health Care or Disability Component will review a Claim within 90 days and provide written notification of its decision. The 90-day period may be extended by 90-days in certain circumstances. If you disagree with the Claim decision, you may file an appeal within 60 days of your receipt of the written notice of denial of a Claim. The Plan administrator will then render a decision within 60 days after receipt of the request for review. In special circumstances, the Plan may make a determination within 120 days after the receipt of your request for review. If such an extension is required, you will be notified in writing.

## LEGAL ACTIONS

### Q19. What should I do if I want to pursue a legal action against the Plan?

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this SPD or, if applicable, the Benefit Documents of a Plan Component, you may lose the right to file suit in state or federal court in the state of Indiana.

The individual named below can be served with legal papers regarding the Plan.

Forest River, Inc.
Attn: David Besinger, Vice President of Human Resources
900 County Road 1,
PO Box 3030
Elkhart, IN 46515

Service of legal process also may be directed to the Plan Administrator.

### Q20. What is the time limit to bring a lawsuit?

Please refer to the applicable Benefit Document for information about the time period applicable to your Claim. If the Benefit Document does not contain any such provision, as permitted by law, you must bring a lawsuit within the following time frames:

- In the case of a Plan Component that is self-insured by your Employer, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Plan Component, the time period for bringing any lawsuit against the insurance company issuing such Plan Component or the Plan will be determined by the terms of the applicable Plan Component. If the Plan Component does not set forth such a time period, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits must be brought within one year of the act or omission giving rise to the claim.

## MISCELLANEOUS

### LEAVE OF ABSENCE

### Q1. What happens to my Benefits if I take a leave of absence?

Depending on the leave policies and procedures adopted by your Employer, you may be able to continue certain Benefits while on an approved leave of absence. If you are eligible to continue certain Benefits, you may be required to complete certain forms or documents and pay towards the cost of coverage.

### Q2. Is my Employer required to comply with the Family and Medical Leave Act (FMLA)?

Yes, your Employer is required to comply with FMLA. The Plan Administrator must continue Health Care Plan coverage while you are on leave protected by the FMLA.

### Q3. What happens if my leave is protected by FMLA?

If your leave is protected under FMLA, you may continue your group health care coverage under the Plan (e.g. Medical, Dental, or Vision) for you and any covered Dependents as long as you continue to pay your portion of the cost for your Benefits during the leave, or if allowed, after the leave.

Your Employer may offer the following options for payment of Contributions:

- ***Paid Leave*** – Contributions will be automatically deducted from payroll.
- ***Unpaid Leave*** – You will be required to submit payment to your Employer for any required Contributions. If you do not pay Contributions in a timely manner, your Employer has at least 15 days before cessation of your coverage to provide you with a notice of the cancellation. Unless your Employer has adopted a longer grace period, you will have **15 days** from the date of the notice to make the required payment. If you fail to make the payment in the permitted time, your coverage will be cancelled.

Any coverage that is terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required Contributions, including any catch-up payments, if applicable, attributable to the period prior to your return from leave.

### Q4. What happens if I experience a "change in status" while on FMLA leave?

If you experience a "change in status" (e.g., change in marital status, number of Dependents, residency, or employment status), you may change your coverage election as if you were actively employed.

### Q5. What happens if I do not return to work following my FMLA leave?

If you do not return to work following your FMLA leave, you may be entitled to COBRA continuation coverage, if applicable. You may also be required to reimburse your Employer for costs of coverage provided to you while you were on unpaid FMLA leave.

### Q6. What happens if my leave is protected under USERRA?

If you are going into or returning from military service, your Benefits may be protected under USERRA. Under USERRA, you may elect to continue coverage under the Plan for up to 24 months. To continue coverage, you must comply with the terms of the Plan, including election and payment of coverage. Moreover, upon return from leave protected under USERRA, your coverage will be reinstated (i.e., begin again).

### LEGAL MATTERS

### Q7. Can I assign my rights under the Plan to another person or third party?

Except as otherwise specifically provided in the Plan or required by law, Benefits payable to you or your Dependents under the Plan may not be assigned, transferred or in any way made over to another party.

Even if an assignment is permitted under the Benefit Document, the Plan Administrator, or any delegated third-party, has the right to determine the validity of the assignment.

### Q8. Is this document a contract between me and my Employer?

No, this document is an SPD and is intended to summarize general provisions of the Plan. This document does not constitute a contract of any type between you and your Employer. Nothing in this document shall give you any right of employment.

## DEFINITIONS

When used in this SPD with initial capital letters, the following words will have the meanings described below unless the content indicates other meanings are intended. If any defined term in this SPD conflicts with the same term contained in an insurance contract or other document, the other document shall govern.

**BENEFIT** – Each benefit available under the Plan, as identified in Appendix A.

**BENEFIT DOCUMENT** – Any policy, contract, or other document that governs the terms of the Benefit.

**CHILD(REN)** – Your child(ren) as defined in a Benefit Document.

**CLAIM** – A request for benefits made by you under the terms of the Benefit Document.

**CLAIMS ADMINISTRATOR** – The Plan Administrator or the third party appointed by the Plan Administrator to review claims submitted by you, including appeals, as applicable.

**CONTRIBUTIONS** – The amount paid by you or your Employer equal to the cost of coverage under a Benefit.

**DEPENDENT** – Your dependent as defined in the applicable Benefit Document.

**DISABILITY PLAN** – The Benefit that provides a Participant supplemental income during a limited or extended period of time due to the inability to work as a result of illness, injury, or accident. The Disability Plan includes a short-term disability plan, other than state-mandated benefits, and a long-term disability plan.

**EMPLOYER** – Your Employer who adopted this Plan is Forest River, Inc. Your Employer will also serve as the Plan Administrator, as defined in the Employee Retirement Income Security Act (ERISA), who is responsible for the day-to-day operations and decisions regarding the Plan, unless a separate Plan Administrator is appointed for all or some of the Plan responsibilities.

**HEALTH CARE PLAN** – Any Benefit that provides medical care, including a Major Medical Option, dental, vision, or an employee assistance program.

**MAJOR MEDICAL OPTION** – A Benefit that provides medical benefits, other than vision or dental benefits, to eligible employees and their Eligible Dependents.

**PARTICIPANT** – An employee of your Employer who has satisfied the eligibility requirements and entered the Plan.

**PLAN** – The Plan described in this SPD is the Forest River, Inc. Welfare Benefit Plan.

**PLAN ADMINISTRATOR** – Your Employer is responsible for the day-to-day administration of the Plan and is the Plan Administrator unless an appointed Plan Administrator is named in the Administrative Information section of this SPD.

**PLAN DOCUMENT** – The document that sets out the official terms and conditions of the Plan.

**PLAN SPONSOR** – The Plan Sponsor is Forest River, Inc.

## ADMINISTRATIVE INFORMATION

### Q1. Who has the authority to make determinations under the Plan?

The Plan Administrator has discretionary authority to interpret and make determinations under the Plan. The Plan Administrator may delegate its authority to third parties regarding Claims administration (e.g., the review and processing of Claims), ministerial services (e.g., recordkeeping, mailing of notices, etc.), and other services, as necessary.

### Q2. What are some of the duties of the Plan Administrator?

The Plan Administrator's duties include, but are not limited to, the following:

- Appointing and supervising a third-party administrator to pay Claims;
- Administering the Plan in accordance with its terms;
- Delegating to any person or entity powers, duties, and responsibilities, as necessary;
- Determining all questions of eligibility, status, and coverage under the Plan;
- Interpreting the Plan, including ambiguities, inconsistencies, omissions, and disputed terms;
- Making factual findings;
- Deciding disputes that may arise relative to a covered person's rights;
- Recommending procedures for filing a Claim for Benefits, review Claim denials, and appeals relating to them, and uphold or reverse such denials;
- Keeping and maintaining the Plan document and all other records pertaining to the Plan;
- Performing all necessary reporting, as required by ERISA, if applicable;
- Establishing and communicating procedures to determine an order's status as a qualified medical child support order; and

- Performing functions necessary for the Plan's administration.

### Q3. Can changes be made to the Plan?

Yes. While the Employer intends to maintain the Plan indefinitely, the Employer may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending Benefits provided under the Plan. If an amendment, suspension, or termination is enacted, the Employer will provide notice, as required by law.

### Q4. What happens if the Plan Administrator or its delegates makes a clerical error?

If the Plan Administrator or its delegated agent make a clerical error, the error will not invalidate coverage. Rather, coverage effective dates will be determined solely in accordance with the provisions of the Plan, including any Benefit Document. Moreover, as permitted by law, the Plan Administrator will make an equitable adjustment as a result of an error or delay.

### Q5. Who is responsible for the day-to-day operations of the Plan?

Your Employer is responsible for the Plan's day-to-day administration.

To assist in operating the Plan efficiently and accurately, your Employer may appoint additional persons or organizations to act on its behalf or to perform certain functions. The Plan Administrator may provide the Claims administration through a third-party Claims Administrator.

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Plan Administrator has the exclusive right to interpret the Plan's provisions. You may contact the Plan Administrator for any further information about the Plan.

### Q6. Who is responsible to administer the Plan's Claims?

The Claims Administrator is responsible to administer the Plan's Claims. The Claims Administrator is:

- The Insurance Issuer or self-insured plan administrator appointed by the Employer.
- The Employer.

Refer to the chart in Appendix A for Claims Administrator contact information.

### Q7. How can I obtain additional information about the Plan?

For additional information regarding the Plan, contact the person or department listed on Page i of this SPD, or refer to the Benefit Documents. Copies of the Plan document, this SPD, and incorporated Benefit Documents are available free of charge from your Employer upon request.

### Q8. If I receive a medical child support order, what should I do?

If you receive a medical child support order, send the order to the Plan Administrator. The Plan Administrator will then review the order to determine if it is a "qualified medical child support order" (QMCSO). If it is determined the order is a QMCSO, the Plan will automatically change your coverage to extend coverage to the Child. Coverage for the Child will begin on the date specified in the order, or if none is specified, the date of the order, as permitted under a Benefit.

You are permitted to obtain, without charge, a copy of the policy and/or procedures governing the QMCSO from the Plan Administrator.

### Q9. When can the Plan Administrator retroactively terminate coverage provided under a Health Care Plan?

A retroactive termination of coverage is referred to as a "rescission." The Plan Administrator may retroactively terminate your coverage or the coverage of your Eligible Dependent if you commit fraud or if you intentionally misrepresent a material fact to the Plan.

### Q10. What is considered fraud or intentional misrepresentation?

Fraud or intentional misrepresentation occurs when you obtain Benefits by fraudulently or intentionally misrepresenting a material fact to the Plan. If you fraudulently or intentionally misrepresent a fact, the Plan Administrator may take certain action, as permitted by law, at its sole discretion.

## YOUR RIGHTS UNDER ERISA

### Q1. Is the Plan subject to the Employee Retirement Income Security Act (ERISA)?

Yes, the Plan is subject to ERISA and you have certain rights summarized in this section.

### Q2. What are my legal rights and protections under the Plan?

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to the following.

***Receive Information About Your Plan and Benefits***

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (if required by ERISA to be prepared) and updated SPD. The administrator may charge a reasonable fee for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary Annual Report.

***Continue Health Care Plan Coverage***
The Plan Administrator is required to continue Health Care Plan coverage for you or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing your COBRA continuation coverage rights.

***Prudent Actions by Plan Fiduciaries***
In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, 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 benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within a certain period of time. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document 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 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 Plan Administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's Claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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, 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.

***Assistance With Your Questions***
If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## COBRA

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this SPD or contact the Plan Administrator.

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

### Q1. What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this Q1. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Each qualified beneficiary is required to pay the entire cost of COBRA coverage, including both employee and employer contributions. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the Health Care Plan.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

## Q2. When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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 coverage.

***NOTICE PROCEDURES:***

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days, or a longer time period if permitted by the Plan, or the latest of:**

- The date of the qualifying event;
- The date coverage would be lost because of the qualifying event; or
- The date on which the qualified beneficiary was informed of the responsibility to provide the notice and procedures for doing so.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must include:

- the Plan's name: Forest River, Inc. Welfare Benefit Plan,
- the name and address of the Participant and any other qualified beneficiaries;
- the Qualifying Event and the date it happened, and,
- be accompanied by any documentation providing proof of the event (e.g., the divorce decree, legal separation agreement).

If provided electronically (if allowed), your notice should be provided by following the Plan Administrator's reasonable procedures established in compliance with the regulations.

**You must provide this notice to the person, department or entity listed on Page i of this SPD.**

## Q3. How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

***Disability extension of 18-month period of COBRA continuation coverage***

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

To qualify for the disability extension, the qualified beneficiary must notify the Plan Administrator of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures described above.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation

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

### Q4. Are there other coverage options besides COBRA continuation coverage?

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

### Q5. Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

### Q6. What if I have additional questions?

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

### Q7. How do I protect my COBRA rights?

***Keep Your Plan Administrator Informed of Address Changes***. To protect your family's rights, you should keep the Plan Administrator informed of any changes in your family members' addresses. You should also keep a copy, for your records, of any notices that you send to the Plan Administrator or its designee.

### Q8. What factors should be considered when determining to elect COBRA continuation coverage?

You may have the right to request special enrollment in another health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends because of a Qualifying Event listed above. You may also have the same special right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

### Q9. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

### Q10. What is the election period and how long must it last?

The election period is the time period within which the qualified beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of 1) the date the qualified beneficiary would lose coverage because of the Qualifying Event, or 2) the date notice is provided to the qualified beneficiary of the qualified beneficiary's right to elect COBRA continuation coverage.

### Q11. Will a waiver made before the end of the election period end a qualified beneficiary's election rights?

If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. The waiver's revocation is an election of COBRA continuation coverage. If a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

### Q12. Is COBRA continuation coverage available if a qualified beneficiary has Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are entitled to Medicare benefits on or before the date on which COBRA continuation coverage is elected. But a qualified beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare or becomes covered under another health Plan.

## Q13. When may a qualified beneficiary's COBRA continuation coverage be terminated?

A qualified beneficiary may waive COBRA continuation coverage during the election period. Except for an interruption of coverage in connection with a waiver, a qualified beneficiary's COBRA continuation coverage must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates.

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the qualified beneficiary.
- The date upon which your Employer ceases to provide any health Plan (including a successor Plan) to any employee.
- The date, after the date of the election, that the qualified beneficiary first becomes covered under a health Plan.
- The date, after the date of the election, that the qualified beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- The later of the following two dates if the qualified beneficiary is entitled to a disability extension.

    1. The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

    2. The earlier of 1) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled, or 2) 29 months after the date of the Qualifying Event.

The Plan can terminate for cause a qualified beneficiary's coverage on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries (for example, for submitting a fraudulent Claim).

If the Plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, and an individual who is not a qualified beneficiary receives coverage under the Plan solely because of the individual's relationship to a qualified beneficiary, the Plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

## Q14. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

## Q15. What is considered timely when paying for COBRA continuation coverage?

Payment is made timely if made no later than 30 days after the first day of the coverage period.

The Plan does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to those providing COBRA continuation coverage.

If you make a timely payment and the payment is less than the amount the Plan requires, the Plan Administrator may consider the amount timely if 1) the amount owed is insignificant, and 2) you pay the amount owed within a reasonable period. A reasonable period is 30 days, and an insignificant amount is considered $50 or 10% of the required amount. Please see the Plan document for additional information.

# PRIVACY RIGHTS UNDER HIPAA

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice describes how your Protected Health Information (PHI) may be used or disclosed under the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PHI or Electronic Protected Health Information (ePHI) means individually identifiable health information held by, or on behalf of, the Plan.

***Uses and Disclosures of Your Information***

The Plan Administrator on behalf of the Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan—including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your Claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and Claims management purposes. Note that the Genetic Information Nondiscrimination Act (GINA) prohibits using PHI that is genetic information for underwriting purposes. In addition, the Plan may disclose your PHI to the Plan Administrator so that the Plan Administrator can perform administrative functions on behalf of the Plan, such as facilitating Claims or appeals.

The Plan also may use or disclose your PHI where required or permitted by law. The Plan Administrator on behalf of the Plan is permitted to use or disclose PHI:

- when required by law;
- for public health activities;
- to report Child or domestic abuse;
- for governmental oversight activities;
- pursuant to judicial or administrative proceedings;
- for certain law enforcement purposes;
- for a coroner, medical examiner, or funeral director in order to obtain information about a deceased individual;
- for organ, eye, or tissue donation purposes;
- for certain government-approved research activities;
- to avert a serious threat to an individual's or the public's health or safety;
- for certain government functions, such as related to military service or national security;

- to comply with workers' compensation laws;
- to a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- to notify a family member or other individual involved in the care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

For any other uses and disclosures of your PHI, the Plan will obtain your written authorization. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes. You may revoke this authorization in writing at any time, provided the Plan has not yet acted while relying on your authorization.

Stricter State Privacy Laws – Under the HIPAA privacy and security rules, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

***Your Rights With Respect To Your Health Information***
You have several rights with respect to your PHI, which are described below. Please contact your Employer's Privacy Officer if you have questions about your rights.

- You have the right to request restrictions on how your PHI may be used or disclosed. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.
- You have the right to receive your PHI confidentially, such as at a location other than your home, if you state in writing that disclosing the information through normal means could endanger you.
- You have the right to inspect and copy your PHI that is maintained by the Plan in a designated record set or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies.
- You have the right to request an amendment to your PHI that the Plan maintains in a designated record set. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.
- You have a right to request an accounting of disclosures that the Plan has made of your PHI during the six years before your request, except for disclosures that you have authorized or for disclosures related to routine treatment, payment, or health care operations of the Plan.
- You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

***Our Duties With Respect To Your Individually Identifiable Health Information***
The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices with respect to your PHI.

***Questions?***
If you have questions or would like more information about the Plan's privacy policies, you may contact the Privacy Officer. The Privacy Officer is responsible for developing and implementing the Plan's privacy policies and procedures.

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing such a complaint.

## OTHER LEGAL NOTICES

### Q1. Do I have any other legal rights and protections under the Plan?

Yes, the Plan is required to comply with other federal regulations, which guarantee certain legal rights and protections, as follows.

***Your Rights Under the Patient Protection and Affordable Care Act***
The Patient Protection and Affordable Care Act (PPACA or ACA) provides certain consumer protections, including the elimination of annual and lifetime limits on benefits, the provision of preventive services without cost sharing, the limitation of out-of-pocket annual costs, the coverage of essential health benefits, the elimination of waiting periods of more than 90 days for coverage to begin, the elimination of pre-existing conditions, and the guarantee of issue and renewal of coverage. As applicable, these provisions are contained within the Benefit Document of the Major Medical Option.

***Your Rights Under the Americans With Disabilities Act***
The Americans with Disabilities Act (ADA) provides that your Employer may not discriminate against you on the basis of disability. In addition, it generally restricts your Employer from obtaining medical information from you but permits your Employer to obtain medical information or request medical examinations as part of a voluntary Wellness Program. Your Employer may not deny you the right to access the Wellness Program on the basis of disability. If you have a disability, your Employer is required to provide a reasonable accommodation or adjustment that allows you to participate in the Wellness Program. Any information provided to your Employer due to participation in the Wellness Program must remain confidential. To request an accommodation, please contact the Plan Administrator or follow the instructions contained in the "Notice Regarding Wellness Program."

***Your Rights Under the Family and Medical Leave Act***
The Family and Medical Leave Act (FMLA) provides that Health Care must be maintained during any period of unpaid leave covered by FMLA under the same conditions as if you continued to work. Moreover, FMLA requires that you be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA. If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse your Employer for its share of health care premiums or Contributions paid on your behalf during your FMLA leave.

***Your Rights Under the Genetic Information Nondiscrimination Act of 2008***
The Genetic Information Nondiscrimination Act of 2008 (GINA) provides that your Employer may not discriminate against you on the basis of genetic information, including adjusting premiums and contribution amounts.

***Your Rights Under the Health Insurance Portability and Accountability Act (Special Enrollment)***
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain special enrollment rights if you decline coverage in the Major Medical Option for yourself or your Eligible Dependents because of other coverage. If you or your Eligible Dependents lose eligibility for that other coverage or if your Employer stops contributing toward your or your Dependent's other coverage, you may be able to enroll yourself and your Eligible Dependent in the Major Medical Option. Generally, you must request enrollment within 30 days after your or your Eligible Dependent' other coverage ends or after your Employer stops contributing toward the other coverage.

If the other coverage is Medicaid or the Children's Health Insurance Program (CHIP), you must request enrollment within 60 days after you or your Eligible Dependents' Medicaid or CHIP coverage ends. Finally, if you have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

***Your Rights Under the Health Insurance Portability and Accountability Act (Health Factors)***
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the Major Medical Option from discriminating against you or your Eligible Dependents based on a health factor. Health factors include your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. Compliance with this provision is not determinative of compliance with any other federal or state laws, including COBRA or ADA.

***Your Rights Under the Mental Health Parity and Addiction Equity Act of 2008***
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provides that if any Major Medical Option under the Plan 1) provides for both medical and surgical benefits and mental health or substance use disorder benefits, and 2) is not subject to increased cost exemption (within the meaning of the MHPAEA), the following conditions apply:

- The Major Medical Option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Major Medical Option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential Participant upon request.
- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant will, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the Participant in accordance with the Claims procedures applicable to the group medical coverage feature.
- The Plan will be operated and constructed in all respects in compliance with the MHPAEA.

"Mental health benefits" and "substance use disorder benefits" are defined in the Major Medical Option applicable to the health insurance option, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.

***Your Rights Under Michelle's Law***
Michelle's Law provides that a Major Medical Option of the Plan that requires a certification of student status for any period of coverage of an Eligible Dependent will comply with Public Law No. 110-381 (2008), as amended from time to time. Eligibility for such coverage for an Eligible Dependent who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the Eligible Dependent to lose eligibility for coverage under any Major Medical Option's coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the medically necessary leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier.

***Your Rights Under Newborns' and Mothers' Health Protection Act***
The Newborns' and Mothers' Health Protection Act (NMHPA) provides that the Major Medical Option of the Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Major Medical Option may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

***Your Maternity Hospital Stay Rights under Indiana State Law***
Every group insurance policy issued in the State of Indiana that provides maternity benefits must provide minimum benefits to a mother and her newborn child that cover a minimum length of postpartum stay at a hospital that is consistent with the minimum postpartum hospital stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. If the patient's attending physician determines further inpatient care is not necessary for the mother or newborn child, a policy or group contract that provides maternity benefits may provide under the policy or group contract a shorter length of postpartum hospital stay than under the guidelines, but the policy or contract must authorize for the mother and the newborn one at-home postdelivery care visit not later than 48 hours following the discharge of the woman and her newborn child from a licensed hospital. However, at the mother's discretion, the visit may occur at the facility of the provider subject to the terms of the policy or group contract.

***Your Rights Under Title VII of the Civil Rights Act of 1964***
Generally, benefits provided under a group health plan must be provided without regard to the race, color, sex (including pregnancy), national origin, or religion of the eligible employee and his or her eligible dependents. A group health plan cannot discriminate on the basis of: eligibility to receive coverage under the Plan; the terms and conditions on which coverage is provided; or, what an employee is charged for coverage.

In addition, under the Pregnancy Discrimination Act of 1978, group health plans must provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as coverage for nonpregnancy-related conditions.

***Your Rights Under USERRA***
The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of Health Care Plan coverage if you are called for active-duty military service. The maximum length of extended coverage under USERRA is the lesser of

- 24 months beginning on the date that the military leave begins, or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional two-percent administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the U.S. Department of Veterans Affairs) incurred as a result of the military service.

***Your Rights Under Women's Health and Cancer Rights Act***
The Women's Health and Cancer Rights Act (WHCRA) requires that a Major Medical Option that provides medical and surgical benefits with respect to a mastectomy provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, copays, and coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable medical option. Please refer to the Major Medical Option's summary of benefits coverage for additional information. If you have other questions, please contact the Plan Administrator.

***Your Rights Under Consolidated Appropriations Act 2021***
The Consolidated Appropriations Act 2021 (CAA) provides for:

- Certain disclosures, including insurance ID cards with stated in-network and out-of-network deductibles and out-of-pocket costs; and provider directories that are current and accurate.
- Notification of the ability to receive transitional care for an ongoing course of treatment when an in-network facility transitions to an out-of-network facility during a course of treatment.
- Protections from surprise medical bills from out-of-network providers for emergency services and out-of-network services at in-network facilities.

Contact your Plan Administrator for this information as it pertains to a particular Benefit.

# Appendix A
# Forest River, Inc. Welfare Benefit Plan

## Plan Components and Claims Administrators

Benefit Documents are part of this SPD. Any update to the Benefit Document will replace any earlier versions for the period defined in the updated Benefit Document.

| Fully-Insured Benefits | Policy/Group No. | Type of Benefit | Claims Administrator<br>*(Use the address & phone number on your ID Card if different)* | |
|---|---|---|---|---|
| **Paramount Dental**<br>100 Madison Avenue<br>Toledo, OH 43604 | 379280325020<br>379283275020<br>379290555020<br>379290565020 | Dental – PPO | Paramount<br>PO Box 928<br>Toledo, OH 43697-0928 | 800-727-1444<br>www.insuringsmiles.com |
| **Provident Life and Accident Insurance Co/Unum**<br>One Fountain Square<br>Chattanooga, TN 37402 | 155183<br>132692 | Individual Disability Insurance (IDI) | Unum Benefits Center<br>PO Box 100158<br>Columbia, SC 29202-3158 | 888-226-7959<br>www.unum.com/employees/file-a-claim |
| **Transamerica Life Insurance Company**<br>4333 Edgewood Road Northeast<br>Cedar Rapids, IA 52499 | G000046683 | Voluntary Term Life | Transamerica<br>PO Box 219<br>Cedar Rapids, IA 52406-0219 | 888-763-7474<br>tebcustresp@transamerica.com<br>www.transamerica.com/portal/claims-materials |
| **Unum Life Insurance Company of America**<br>1 Fountain Square<br>Chattanooga, TN 37402<br>*(Voluntary Worksite Effective January 1, 2026)* | 951841 | Basic Life/AD&D (with EAP)<br>Voluntary Life/AD&D | Unum Benefits Center<br>PO Box 100158<br>Columbia, SC 29202-3158 | Life: 800-445-0402<br>Disability: 800-858-6843<br>EAP: www.unum.com/employees/file-a-claim<br>Worksite: 800-635-5597<br>www.unum.com/employees/file-a-claim |
| | 951839 | Short-Term Disability | | |
| | 951840 | Long-Term Disability | | |
| | 984567 | Voluntary Accident | | |
| | 984568 | Voluntary Critical Illness | | |
| | 984569 | Voluntary Hospital Indemnity | | |
| **Vision Service Plan (VSP)**<br>3333 Quality Drive<br>Rancho Cordova, CA 95670 | 30068748 | Vision | *In-Network:*<br>VSP<br>PO Box 495907<br>Cincinnati, OH 45249-5907<br>*Out-of-Network:*<br>VSP<br>PO Box 495918<br>Cincinnati, OH 45249-5918 | 800-877-7195<br>www.vsp.com/faqs/claims-reimbursement |
| **Voya/Reliastar Life Insurance Company**<br>20 Washington Avenue South<br>Minneapolis, MN 55401<br>*(Terminated Effective December 31, 2025)* | 71143-8 | Voluntary Worksite Benefits (Accident, Critical Illness, Hospital Indemnity) | Voya Claims<br>PO Box 320<br>Minneapolis, MN 55440 | 877-236-7564<br>www.voya.com/claims |

| Self-Insured Benefits | Contract No. | Type of Benefit | Claims Administrator<br>*(Use the address & phone number on your ID Card if different)* | |
|---|---|---|---|---|
| **Allied Benefit Systems, Inc.**<br>200 West Adams Street, Suite 500<br>Chicago, IL 60606 | A22100 | Medical – PPO | Allied<br>PO Box 909786-60690<br>Chicago, IL 60690 | 800-288-2078<br>www.alliedbenefit.com |
| **CapitalRx**<br>1 World Trade Center<br>New York, NY 10007 | JD145 | Prescription Drugs | CapitalRx<br>9450 SW Gemini Drive, Suite 87234<br>Beaverton, OR 97008 | 888-832-2779<br>www.cap-rx.com |

**Non-ERISA Benefits** In addition to the above Component Plans, eligible employees are offered non-ERISA welfare benefits. Such non-ERISA benefits are not governed by ERISA and include the following benefit plan(s):

| Issuer/Provider | Type of Non-ERISA Benefit |
|---|---|
| **Metropolitan Life Insurance Company (MetLife)** | Identity Theft Protection |

# Appendix B
# Forest River, Inc. Welfare Benefit Plan

## Eligibility and Participation Requirements

*An employee who is determined to be benefit-eligible as of his or her start date shall be able to participate in the Plan as of the Coverage Date specified below.*

| Employee Class | Working Hours Minimum | Benefits Offered | Date Coverage Begins |
|---|---|---|---|
| Key Executive Employees | 20 hours per week | All Benefits Included in Appendix A | First day of the month coinciding with or following two months of employment |
| Salary Employees | 20 hours per week | All Benefits Included in Appendix A except IDI | |
| Hourly Employees | 20 hours per week | All Benefits Included in Appendix A except LTD and IDI | |
| Part-Time Employees | Working some weekly hours at least 75% of the time (39 weeks out of 52) | Medical | |

***Dependent Eligibility***

Unless specified otherwise under the applicable Plan Component's benefit documents, coverage for dependents, if elected, begins on the date the Employee's coverage begins (provided the Employee timely enrolls them in coverage). Mid-Plan Year elections for newly acquired Dependents may also be permitted under certain circumstances.

Dependent Definitions. For purposes of eligibility and participation in this Plan, Dependent definitions shall have the same meaning set forth in each applicable Plan Component's benefit documents, or if not defined in the applicable Plan Component documents, in accordance with the policies adopted by the Employer.

Proof of Dependent Status. Your Employer reserves the right to verify a Dependent is eligible or continues to be eligible for coverage under the Plan. Documents requested may include (but are not limited to) copies of birth certificates, court orders, divorce decrees or marriage certificates as needed to establish dependent status. Dependent eligibility determinations made by your Employer shall be final, binding and conclusive on all parties claiming an interest in the Plan.

Dual Coverage Prohibited. Except as specifically provided otherwise in an applicable Plan Component's Benefit Documents, in no event will an employee be covered under a Plan Component as both a participant and a dependent, or a dependent be covered under a Plan Component as a dependent of more than one participant.

***Rehire Rule***

Unless otherwise specified to the contrary in the Benefit Documents for a Component Plan, an employee who is rehired prior to the end of a 13-consecutive week period of time after date of termination will be credited with hours of service met towards the eligibility waiting period during his or her preceding period of employment. Otherwise, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and participation requirements for his or her employment class.

***Special Eligibility Rules for Variable Hour, Part-Time, and Seasonal Employees***

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status ("ACAFT") under special eligibility rules for variable hour, part-time, and seasonal employees. In the event your Employer adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

For purposes of these special eligibility rules (known as either the "Look-Back Measurement Method" or "Monthly Measurement Method"), a variable hour, part-time or seasonal employee will achieve ACA-FT status after averaging 130 or more hours of service per month (or 30 or more hours of service per week) during a period of time spanning a specific number of consecutive months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the "Stability Period." The maximum length of any Measurement Period or Stability Period shall not exceed 12-consecutive months.

If applicable, details regarding the Look-Back Measurement Method and/or Monthly Measurement Method adopted by your Employer (e.g. the classes of employees it applies to, a description of each type of measurement period, breaks-in-services rules, and procedures used to count hours of service) are available upon request from the Plan Administrator.

***Cessation of Participation***

Unless otherwise stated in the applicable Benefit Documents, your coverage will cease upon the earliest of the following:

- The date or end of the month (as applicable under each Plan Component) in which you cease to satisfy the eligibility requirements for a particular Plan Benefit. This may result from your death, reduction in hours, or termination of active employment, or if your hours of service are tracked under the ACA Look-Back Measurement Method, it may result because you lose ACA full-time status during a subsequent Standard Stability Period;
- The end of the period for which you paid your required Contribution if the Contribution for the next period is not paid when due;
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") as described in the "Your Rights Under USERRA" section; or,

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the contract or agreement, or by discontinuance of Contributions for your Employer.

Coverage for your spouse and other Dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Documents for the Plan Components. In addition, their coverage will terminate:

- The date or end of the month on which your covered spouse or Child is no longer considered an eligible Dependent;
- The date, end of the month, or end of the Plan Year in which your Dependent Child attains a Plan Component's limiting age (unless the Plan Component allows for the continuation of coverage for a mentally or physically disabled Child who is primarily dependent on you for support);
- The end of the pay period in which you stop making Contributions required for Dependent coverage; or,
- The date that a Child is no longer covered under QMCSO, if the Child is not otherwise eligible to participate in the Plan.

Depending on the reason for termination of coverage, you and your covered Dependents may have the right to continue health coverage temporarily under COBRA. See the "COBRA" section of this SPD for details.

# APPENDIX C
# Forest River, Inc. Welfare Benefit Plan

## Premium Assistance under Medicaid and CHIP

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Medicaid and CHIP+** | **FLORIDA – Medicaid** |
| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **GEORGIA – Medicaid** | **INDIANA – Medicaid** |
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: (678) 564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |

| KENTUCKY – Medicaid | LOUISIANA – Medicaid |
|---|---|
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or<br>1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: -800-977-6740.<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/health-care-coverage/<br>Phone: 1-800-657-3672 | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311<br>(Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |

| TEXAS – Medicaid | UTAH – Medicaid and CHIP |
|---|---|
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website: https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP<br>(1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565