GRAY & SON/MARYLAND PAVING MGMT, INC.
GROUP HEALTH PLAN

SUMMARY PLAN DESCRIPTION

Effective April 1, 2016
(Schedule of Benefits effective April 1, 2021)

ABOUT THIS SUMMARY

The following is a summary of some of the principal features of the Gray & Son/Maryland Paving MGMT, Inc. Group Health Plan (the Plan). We urge you to read this summary carefully.

This summary is the "Summary Plan Description" for the Plan and is meant to summarize the Plan in easy-to-understand language. However, in the event of any ambiguity or any inconsistency between this Summary Plan Description and any formal Plan documents, the Plan documents will control.

Copies of the formal Plan documents for the Plan are on file at Gray & Son/Maryland Paving MGMT, Inc. and are available to you for inspection at a time and place mutually agreeable to you and to Gray & Son/Maryland Paving MGMT, Inc.

If anything in this Summary Plan Description is not clear to you, or if you have any questions about Plan benefits or Plan claims procedures, please contact the Plan Administrator.

When this Summary Plan Description uses the term "Plan Sponsor", it is referring to Gray & Son/Maryland Paving MGMT, Inc., which sponsors the Plan. When this Summary Plan Description uses the term "Employer", it is referring to all of the Plan's participating Employers, which, effective April 1, 2016, includes the Plan Sponsor and the employers listed below. To determine whether your employer is a participating Employer in the Plan on any given date, contact the Plan Administrator at the address provided later in this Summary Plan Description.

Participating employers:

Gray & Son, Inc.
Gray & Son/Maryland Paving MGMT LLC

GRAY & SON/MARYLAND PAVING MGMT, INC. GROUP HEALTH PLAN
SUMMARY OF MATERIAL MODIFICATIONS

TO: Participants in the Gray & Son/Maryland Paving Mgmt, Inc. Group Health Plan

FROM: Plan Administrator

DATE: April 1, 2021

RE: Summary of Material Modifications

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the Gray & Son/Maryland Paving Mgmt, Inc. Group Health Plan (the "Plan") to revise the Plan's Health FSA to provide for coverage of certain newly eligible expenses and to make some additional temporary changes that are required or permitted because of the current COVID-19 National Emergency. Please review this SMM carefully to familiarize yourself with the changes, and save it with your SPD (or attach it to any paper copy of your SPD). Except as otherwise provided in this SMM, the changes described in this SMM are effective April 1, 2020.

1. New Eligible Health FSA Expenses. Effective April 1, 2020, the Plan's health care flexible spending account (Health FSA) feature is amended to provide for reimbursement of the following additional eligible expenses for you and your eligible child, spouse or dependent (as determined under the terms of the Health FSA):

- Expenses for over-the-counter medicine that you pay at any time during the current plan year are now eligible for reimbursement under the Health FSA regardless of whether the medicine has been prescribed for you (or your eligible spouse, child or dependent). Previously, over-the-counter medicine was covered only if it was provided based on a prescription. Note that, even though a prescription is no longer required for over-the-counter medicine to be reimbursed, the Health FSA still does not reimburse expenses for over-the-counter items that do not qualify as medicine under Internal Revenue Service rules (such as vitamins or nutritional supplements).
- Expenses for menstrual care products that you (or your eligible spouse, child or dependent) pay at any time during the current plan year are now eligible for reimbursement under the Health FSA. For this purposes, "menstrual care product" means a tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation.
- Expenses for personal protective equipment such as masks, hand sanitizers and sanitizing wipes, for use by you, your spouse or your dependents for the primary purpose of preventing the spread of the Coronavirus Disease 2019.

2. Special Election Change Rules. The following new subsection (g), which allows employees to make certain benefit election changes during the Plan Year that began April 1, 2020 that would not normally be permitted, is added to the end of the "Participation" section of your SPD:

(g) Special Election Changes. Because of the COVID-19 pandemic, during the Plan Year that began April 1, 2020 only, you may elect to enroll in a health care flexible spending account under the Plan (Health FSA) or to increase or decrease contributions to a

Health FSA if you are already enrolled.

If you make a change to your Health FSA contributions based on the above rules, that change will affect the maximum amount available under the Health FSA for the rest of the Plan Year. In such cases, the maximum amount available for expenses incurred during the rest of the Plan Year (on or after the effective date of the change in contributions) will be calculated by adding (1) the contributions (if any) credited to your Health FSA plus any carryover contributions through the effective date of your change in contributions, to (2) the total contributions scheduled to be made to your Health FSA for the rest of the Plan Year based on your new contribution election and subtracting (3) all reimbursements made during any portion of the Plan Year. The maximum reimbursement amount available for expenses incurred before the effective date of your change in contributions will continue to be based on the limit that applied before your election change. For example, if you originally elected to contribute $1,200 ($100 per month) to a Health FSA for the Plan Year, halfway through the year (after you have contributed $600), you elect to increase your contributions to $200 per month, your maximum reimbursement amounts for the first six months of the Plan Year would still be $1,200, based on your original election, but your maximum reimbursement amount for expenses incurred during the second half of the year would be $1,800 (based on the $600 contributed before the change plus the $1,200 you are expected to contribute for the remaining six months). Remember that, in all cases, the amount available for reimbursement is always reduced by all previous reimbursements for the same plan year, regardless of when the reimbursement was made.

If you wish to change your Health FSA election to reduce contributions, note that your election change will be limited as needed to ensure that your total expected contributions for the remainder of the Plan Year will be, together with all your previous contributions for the Plan Year, enough to cover at least the amount already reimbursed by the Health FSA on the date the election is to be implemented, as determined by the Administrator.

Election changes under this subsection (g) may be limited based on uniform and consistent administrative rules established by the Employer. You will be informed if any of these rules affect your requested election change. Your new elections will take effect as soon as practicable after the date you complete and submit any required election change form or process and after the changes are approved by the Plan Administrator, and will be effective for the balance of the Plan Year in which the new election becomes effective or, for all other coverage, until you make another change to the applicable benefits in accordance with Plan procedures.

3. Health FSA Carryover Inflation Adjustments. Effective starting with the Health FSA plan year beginning in 2020, the Plan's maximum carryover contribution is increasing. The carryover contribution feature previously provided that up to $500 in unused balance remaining in your Health FSA at the end of a Plan Year could be carried over to the next Plan Year, so that you can access that amount to use for eligible expenses incurred during the next Plan Year. The IRS now allows for this maximum carryover amount to be adjusted each year for inflation. For the Health FSA Plan Year starting in 2020, the maximum amount permitted by the IRS to be carried over at the end of the 2020 Plan Year to the next Plan Year is increasing to $550 and the Plan's maximum carryover contribution amount is increasing to that amount. For later Plan Years, the maximum

carryover contribution amount will be adjusted to match the new maximum amount announced by the IRS that applies for each Plan Year.

4. Full FSA Carryover. For the Plan Year ending March 31, 2021 only, if you are covered under the Plan's health care flexible spending account (Health FSA) on the last day of the Plan year and you have an Unused Balance remaining credited to a your Health FSA, that Unused Balance will automatically be carried over to the next Plan Year and will be available to pay expenses incurred during the next Plan Year (the "Carryover Plan Year"). For purposes of this paragraph, your Unused Balance on any specified date is equal to the total amount actually contributed to your Health FSA for the Plan Year through that date minus any reimbursements paid through the applicable FSA through that date.

Unless the Administrator announces a different deadline for submitting claims for reimbursement, as a result of this change, requests for reimbursement under a Health FSA for expenses incurred during the Carryover Plan Year described above must be submitted no later than 12 months after the deadline that would otherwise apply for that Plan Year under the normal terms of the Plan.

5. Temporary Deadline Extensions. Effective March 1, 2020, certain time periods described in your SPD (and in COBRA notices or other Plan materials) have been extended because of the National Emergency declared with regard to the COVID-19 (coronavirus) pandemic.

Specifically, the Plan will comply with all applicable requirements of the guidance issued by the Employee Benefits Security Administration and the Internal Revenue Service (the "Agencies") on May 4, 2020, which extended certain time frames relating to special enrollment rights, COBRA continuation coverage and claims, appeals and external review procedures for employee benefit plans. To comply with that guidance, the Plan will not count any days during the "Outbreak Period" (as defined below) in determining if any person has satisfied a requirement relating to the following time periods or deadlines:

(1) The 30-day period (or 60-day period, if applicable) for requesting a special enrollment (as described in part (f) of the "Participation" section of your SPD);

(2) The 60-day period for a COBRA qualified beneficiary to elect COBRA continuation coverage, as described in a COBRA qualifying event notice or other materials provided on behalf of the Plan;

(3) Any time period for a COBRA Qualified Beneficiary to make a COBRA premium payment (including any COBRA "grace period"), as described in a COBRA qualifying event notice or other materials provided on behalf of the Plan;

(4) The time period for individuals to notify the plan of a COBRA qualifying event or determination of disability under ERISA; as described in your SPD or in a COBRA qualifying event notice or other materials provided on behalf of the Plan;

(5) Any deadline for filing a claim for a benefit offered under the Plan that is subject to ERISA (as described in the "Claims Procedures" section and other parts of your SPD (such as the health FSA section) or in a Benefit Booklet);

(6) Any deadline under the Plan's Claims Procedures for an individual to request an internal appeal of any adverse claim determination;

(7) The deadline for an individual to request external review following an adverse benefit determination, as described in the External Review language in the "Claims Procedures" section of your SPD; and

(8) The deadline for a claimant to provide additional information needed to complete a request for external review, as described in the External Review language in the "Claims Procedures" section of your SPD.

For purposes of the Plan and this SMM, the "Outbreak Period" is the period beginning on the later of (i) March 1, 2020 or (ii) the "Applicable Event Date" (as defined in the chart below) and ending on the earlier of (a) 60 days after the announced end of the National Emergency Period that began on March 1, 2020 relating to the COVID-19 outbreak (or on any other date that is announced by the Agencies) or (b) one year from the Applicable Event Date. For purposes of the above time periods or deadlines that would otherwise apply under the Plan without this SMM, days before the Outbreak Period and days beginning after the Outbreak Period will be combined in determining if the applicable time period requirement has been satisfied, but all days during the Outbreak Period will be ignored. For example, if a 30-day special enrollment period began 25 days before the Outbreak Period, that special enrollment period would remain open for the entire Outbreak Period and would end five days after the end of the Outbreak Period.

Event	Event type	Applicable Event Date
(1)	Special enrollment event	First day of 30-day or 60-day special enrollment period
(2)	Initial COBRA election	First day of 60-day COBRA election period
(3)	Initial COBRA payment Monthly COBRA payment	First day of 45-day initial payment period First day of 30-day payment grace period
(4)	COBRA qualifying event notice	First day of 60-day period for providing notice
(5)	Initial claim	Date of claim
(6)	Internal or external appeal	Date of receipt of claim denial
(7)	Request for external review	Date of notice of adverse determination on appeal
(8)	Perfection of external appeal	Date of receipt of notice of need for information

Note that these special Outbreak Period rules simply extend certain time periods and do not change any related provisions of the Plan. For example, enrollment based on a special enrollment period election will become effective as described in the SPD based on the date the request for enrollment is made. For special enrollment periods that are not based on the birth, adoption or placement for adoption of a child, that means coverage becomes effective no later than the start of the next month after the request is made. So, waiting until later in the extended special enrollment period to request enrollment will also mean that enrollment is delayed as well.

6. COVID-19 Testing Coverage. Effective March 18, 2020 and continuing as long as the public health emergency relating to the coronavirus pandemic continues (as determined by the Secretary of Health and Human Services), the following benefits are covered under the Plan's medical coverage for any covered person, based on the special rules described below:

- COVID-19 (Coronavirus) Testing: Expenses for any FDA-approved test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID–19; and

- COVID-19 (Coronavirus) Testing Provider Visits: Expenses for a health care provider visits, including in-person office visits and telehealth visits and emergency room or urgent care center visits, that result in an order for or the administration of a COVID-19 test, including any items or services provided as part of the visit that are related to the administration or furnishing of a COVID-19 test or determining the need for such a test.

The above benefits will be covered by the medical Plan without regard to whether the covered person has satisfied any deductible that would otherwise apply and without any copayment or coinsurance requirements being imposed on the covered person.

For COVID-19 Testing provided by an in-network provider and COVID-19 Testing Provider Visits with an in-network provider, you will not be responsible for paying any amount for those expenses. If you use an out-of-network provider for these services, the medical Plan will pay the out-of-network provider no less than the amount required by applicable law.

If a health care provider visit does not result in a COVID-19 test being administered or ordered, note that the visit will be subject to the normal terms of the Plan, so it may be subject to a deductible and/or copayment or coinsurance requirements. Also, if a provider visit involves other services that are not related to an evaluation for a COVID-19 test, those other services may be subject to the normal terms of the Plan.

7. COBRA Notice Changes. Effective immediately, the COBRA Notice section of your SPD is revised to replace the current "**Are there other coverage options besides COBRA continuation coverage?**" question and answer with the following questions and answers:

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**.

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 (https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods) 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

8. Notwithstanding any provisions of this SPD to the contrary, the Plan will comply with the COBRA premium assistance provisions of the American Rescue Plan Act of 2021, including any notice requirements, to the extent they apply to continuation coverage available under the Plan. If you have any questions, please contact the Plan Administrator at the address or phone number provided at the end of this SMM.

9. New Benefits Booklets. Any new Benefits Booklets which have been, or will be, distributed to you are part of your SPD.

If you have questions about these Plan changes, this SMM, or your SPD, please contact the Plan Administrator at the following address or at (410)771-4311:

Gray & Son/Maryland Paving Mgmt, Inc.
c/o Human Resources Department
430 West Padonia Road
Timonium, MD 21093

GRAY & SON/MARYLAND PAVING MGMT, INC. GROUP HEALTH PLAN

SUMMARY OF MATERIAL MODIFICATIONS

TO: Participants in the Gray & Son/Maryland Paving MGMT, Inc. Group Health Plan

FROM: Plan Administrator

DATE: April 19, 2020

RE: Summary of Material Modifications

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the Gray & Son/Maryland Paving MGMT, Inc. Group Health Plan (the "Plan").

Please review this SMM carefully to familiarize yourself with the changes, and please attach this SMM to the front of your SPD. These changes are effective March 1, 2020. These changes will remain in effect only while there is a declared public health emergency (as defined under federal law) due to COVID-19.

I. In response to the threat of COVID-19, the Plan is temporarily allowing telemedicine benefits for PCP, Specialist and mental health services that will be payable at the same level of benefits as an office service.

II. The Plan will cover all COVID-19 Tests and any office visit, telehealth, ER, or Urgent Care related the diagnosing of COVID-19 at 100%

If you have questions about these Plan changes, this SMM, or your SPD, please contact the Plan Administrator at the following address or phone number:

Gray & Son/Maryland Paving MGMT, Inc.
430 West Padonia Road
Timonium, MD 21093
(410)771-4311

GRAY & SON/MARYLAND PAVING MGMT, INC. GROUP HEALTH PLAN

SUMMARY OF MATERIAL MODIFICATIONS

TO: Participants in the Gray & Son/Maryland Paving MGMT, Inc. Group Health Plan

FROM: Plan Administrator

DATE: April 1, 2020

RE: Summary of Material Modifications

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the Gray & Son/Maryland Paving MGMT, Inc. Group Health Plan (the "Plan"). Please review this SMM carefully to familiarize yourself with the changes, and please attach this SMM to the front of your SPD. These changes are effective April 1, 2020, unless otherwise indicated below.

1. In the "About This Summary" section of your SPD, the last paragraph is revised to read as follows:

   When this Summary Plan Description uses the term "Plan Sponsor", it is referring to Gray & Son/Maryland Paving MGMT, Inc., which sponsors the Plan. When this Summary Plan Description uses the term "Employer", it is referring to all of the Plan's participating Employers, which, effective April 1, 2020, includes the Plan Sponsor, along with other employers. To determine whether your employer is a participating Employer in the Plan on any given date, contact the Plan Administrator at the address provided later in this Summary Plan Description. A list of participating employers is available free upon request.

2. Effective September 1, 2019, in the "Health Coverage Insurance and Funding Information" section of your SPD, the last paragraph is revised to read as follows:

   Superior Vision, 881 Elkridge Landing Road, #300, Linthicum, MD 21090, is the insurer and claims processor of your vision benefits under the Plan. The Plan's vision benefits are fully guaranteed under the policy of insurance issued by this company.

3. Any new Benefits Booklets which have been, or will be, distributed to you are part of your SPD.

If you have questions about these Plan changes, this SMM, or your SPD, please contact the Plan Administrator at the following address or phone number:

Gray & Son/Maryland Paving MGMT, Inc.
430 West Padonia Road
Timonium, MD 21093 (410)771-4311

GRAY & SON/MARYLAND PAVING MGMT, INC. GROUP HEALTH PLAN

SUMMARY OF MATERIAL MODIFICATIONS

TO: Participants in the Gray & Son/Maryland Paving MGMT, Inc. Group Health Plan

FROM: Plan Administrator

DATE: April 1, 2019

RE: Summary of Material Modifications

This Summary of Material Modifications ("SMM") amends certain provisions of your Summary Plan Description ("SPD") for the Gray & Son/Maryland Paving MGMT, Inc. Group Health Plan (the "Plan").

Please review this SMM carefully to familiarize yourself with the changes, and please attach this SMM to the front of your SPD. These changes are effective April 1, 2019, unless otherwise indicated below.

2. The second paragraph of the "Health Coverage Insurance and Funding Information" Section of your SPD is revised to read as follows:

US-Rx Care, 6412 N. University Drive, Suite 113, Tamarac, FL 33321 is the claims processor of your prescription drug benefits under the Plan. The Plan's prescription drug benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance company.

3. The following is added to the beginning of the "Dependent Eligibility" Section of your SPD:

(NOTE: This Dependent Eligibility section does <u>not</u> apply to flexible spending account benefits. For details on whether a family member's expenses can be covered under a flexible spending account, see the separate explanations of those benefits in the "Summary of Available Benefits" section.)

4. Effective January 1, 2018, the first paragraph of the "Dependent for Federal Income Tax Purposes*"* Section of your SPD is revised to read as follows:

Whether someone is your *dependent for federal income tax purposes* is determined under IRS rules. For details on the requirements for someone to be your federal income tax dependent, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* under the Plan. However, for purposes of this Plan's health benefits, note that even if your family member would not qualify as your dependent for federal income tax purposes under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another

person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for purposes of the Plan's dependent eligibility requirements.

5. The last sentence of the first paragraph of the "Election Periods After Initial Election Period" Section of your SPD is revised to read as follows:

However, this automatic carry-over of previous elections does not apply to your elections regarding participation in the Plan's health care flexible spending account. If you fail to complete and submit a new Election Form for that benefit, you will not automatically receive coverage.

6. The second paragraph of the "Changes of Election Because of Changes in Cost or Coverage" Section of your SPD is revised to read as follows:

The rights described in paragraphs (i)-(iv) below are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan. Also, the rights described in (i)-(iv) below do not apply to elections involving a health care flexible spending account. You may not change the amount you contribute to a health care flexible spending account because of a change in cost or a change in coverage of another benefit option and you may not make an election change for any other benefit option because of a change in the cost or coverage under your health care flexible spending account or the health care flexible spending account of your spouse or dependent.

7. The following is added to the end of the "Revoking Medical Coverage Because of Reduction In Hours" Section of your SPD:

Note that this rule applies only to medical coverage (not including any health care FSA) and does not allow you to change your election of benefits for any other coverage offered under the Plan.

8. The fourth to last paragraph of the "Termination of Coverage" Section of your SPD is revised to read as follows:

Also, if you take a leave of absence from employment with the Employer because of military service and your health coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue health coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in the COBRA notice section of this Summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different and the special COBRA coverage limits that apply to health care flexible spending accounts do not apply to USERRA continuation coverage under a health FSA. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the date coverage would terminate under the Plan's normal termination provisions for a reason other than your

military service (2) the last day of the 24-month period beginning on the date your military leave of absence begins; or (3) the day after the date on which you fail to timely apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

9. The following is added to the end of the Medical/Prescription Drug Coverage description in the "Summary of Available Benefits" Section of your SPD:\

In addition to other coverages provided under the Plan, the Plan provides coverage for the following prescription drugs facilitated by the Plan's vendor, ScriptSourcing:

1. Drugs acquired through ScriptSourcing's Manufacturer's Assistance Program ("MAP"). These are specialty drugs and other higher-cost drugs specifically identified by ScriptSourcing as MAP drugs, that are not on the Plan's formulary list, and that are acquired from their manufacturers, through ScriptSourcing's efforts, at no cost or a lower cost. (Any reduced costs paid for these drugs and ScriptSourcing's fees to the employer under the MAP, are considered claims expenses for all purposes of this Plan.)

If an attempt by ScriptSourcing to acquire such a drug from its manufacturer at no cost or a lower cost is unsuccessful, the Plan's Pharmacy Benefit Manager may determine that the drug is medically necessary and in such a case the cost of the drug is considered a claims expense for all purposes of this Plan.

2. Drugs acquired through ScriptSourcing's International Prescription Program ("IPP"). These are drugs specifically identified by ScriptSourcing as internationally-sourced and are made available to Plan participants with no co-pay. The costs of these internationally-sourced drugs and ScriptSourcing's fees to the employer under the IPP are considered claims expenses for all purposes of this Plan.

10. The following is added to the end of the "Summary of Available Benefits" Section of your SPD:

Health Care Flexible Spending Account. If you are eligible to participate in the Plan, $2,700 per Plan Year, credited to your health care flexible spending account (Health FSA). The Plan's maximum contribution amount is required by federal law. The maximum amount is adjusted by the IRS each year based on inflation. The Plan's maximum contribution amount will also be automatically adjusted each year based on the new maximum announced by the IRS, unless the Employer announces a different limit during open enrollment.

You can receive amounts from this Account, in cash, as reimbursement for eligible medical expenses (as defined in the Plan) incurred during the Plan Year and while you are a participant in the Health FSA.

Generally, eligible medical expenses are expenses that you, your spouse or your dependent (determined as described in the next paragraph) have incurred that are not covered under any plan or employer-provided medical/prescription drug coverage, that meet the Internal Revenue Code's definition of medical expenses (including legally obtained

prescription drugs and over-the-counter medicine), and that have not been taken as a deduction in any tax year. Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

For purposes of Health FSA reimbursements, "dependent" includes:

(1) your spouse (as determined under federal law);

(2) your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year in which the expense is incurred (even if the child is not your dependent for tax purposes); and

(3) any person who is expected to be your *dependent for federal income tax purposes* (as defined below) for the calendar year in which the expense is incurred.

For details on the requirements for someone to be your *dependent for federal income tax purposes*, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* for Health FSA benefits. However, for purposes of the Health FSA, note that even if your family member would not qualify as your federal income tax dependent under the IRS rules solely because (1) you are a dependent of someone else, or (2) he or she files a joint income tax return with another person for the current year, or (3) his or her income is too high for you to claim as a dependent on your tax return, that family member is still considered to be your *dependent for federal income tax purposes* for Health FSA benefits. The Plan Administrator always has the right to require documentation that an individual qualifies as your spouse or dependent for health FSA purposes and to deny benefits if you fail to provide adequate documentation when required. If you have any question about whether someone qualifies as your dependent for purposes of the Health FSA, you should consult a tax advisor.

To be reimbursed from your Health FSA, you must submit to the Plan Administrator a request for reimbursement on a form provided by the Plan Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Plan Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests no later than 90 days after the earlier of (1) the last day of the Plan Year in which the expenses were incurred or (2) the date your participation in the Health FSA ends.

You may be provided with a debit card that may be used to pay for eligible expenses directly from your Health FSA. If so, before you may use the debit card, you must agree in writing that you will use the card only to pay for eligible medical expenses for you or your spouse or dependents (as determined under federal tax law), that you will not use the debit card for any medical expense that has already been reimbursed, that you will not seek reimbursement under any other health plan for any expense paid with a debit card, and that

you will obtain and keep sufficient records (including invoices and receipts) for any expense paid with the debit card. You may be required to provide receipts to the Plan to substantiate the expenses paid through a debit card. Additional details about the use of the debit card will be provided to you at the time the card is provided.

Please note that amounts held in your Health FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited, unless the amount is eligible to be carried over to the next Health FSA Plan Year, as described below.

Health FSA Carryover Feature

The Health FSA includes a "carryover" feature that provides that up to $500 of your unused balance in the Health FSA at the end of a Plan Year will not be forfeited but will instead be carried over to the next Plan Year (if you are still an eligible employee on the first day of the next Plan Year).

> *Example: If you elected to contribute $2,000 to your Health FSA for the 2019 Plan Year, but you have used only $1,400 of that amount when the Plan Year ends on March 31, 2020 and you do not have any more eligible expenses to submit for reimbursement, the remaining $600 normally would have been forfeited because of the "use it or lose it" rule that applies to the Health FSA under federal tax law. With the carryover feature, you would still forfeit $100 of that unused balance but the remaining $500 will automatically be carried over to the Plan Year that starts on April 1, 2020, so you can use that amount to pay eligible expenses you incur any time during the 2020 Plan Year.*

Note that you can still elect to contribute the maximum amount permitted under the Health FSA for each Plan Year even if you have an amount that is carried over from a previous year, so the carryover amount does not reduce the amount you can contribute each year. It just increases the amount available to you for the year.

You also should be aware that carried over amounts can still be used to pay expenses from the original Plan Year, as long as you submit your request for reimbursement before the deadline for submitting claims for that original Plan Year. For example, as described in the example above if you used only $1,400 of your $2,000 contribution for the 2019 Plan Year by March 31, 2020, $500 of your unused balance would be carried over to the next Plan Year and could be used to reimburse expenses incurred during that Plan Year. However, if you still have expenses for the 2019 Plan Year that you need to submit for reimbursement, you still may submit those reimbursement requests and be paid up to $600 for those expenses, as long as you submit your request by the deadline for submitting expenses for that Plan Year.

Of course, if the $500 that was eligible for carryover is paid out to reimburse you for expenses incurred during the second plan year, it will no longer be available to pay expenses incurred during the first Plan Year. For that reason, it is important that you submit all requests for the first Plan Year first to make sure they are reimbursed first.

The carryover feature applies to the Health FSA only. It does not apply to the Plan's Dependent Care FSA.

Qualified Reservist Distributions

If you are called or ordered to active duty in a United States reserve component for a period of 180 days or longer or for an indefinite period (or for a shorter period that is later expanded to 180 days or longer), and the amount you have received in reimbursements from your Health FSA for the Plan Year is less than the amount you have contributed, you may request a Qualified Reservist Distribution of your unused balance (the difference between what you have contributed and the amount of reimbursements you have received). The distribution generally would be treated as taxable compensation to you. You must request the distribution before the end of the Plan Year during which you are called or ordered to active duty. If you request a distribution, you may continue to submit claims for expenses incurred before you made your request, but you may not submit claims for expenses incurred after that date. Your request must include a copy of the document that orders or calls you to active duty (if not already provided to the Employer). If you qualify for a Qualified Reservist Distribution, the distribution will be made within a reasonable period (no later than 60 days) after you request it. Once you receive a distribution equal to your entire unused balance, you will no longer be a participant in the Health FSA for that Plan Year and will not be able to submit or be reimbursed for any additional claims for eligible medical expenses. To request a Qualified Reservist Distribution or for more information, you should contact the Plan Administrator at the address provided in this Summary.

11. The first paragraph of the "Continuation Coverage under COBRA (COBRA Notice)" Section of your SPD is revised to read as follows:

This "COBRA Notice" section of your Summary Plan Description applies to employees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, "Plan" refers only to the medical/prescription drug, dental, vision, EAP and health care flexible spending account benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

12. The following is added to the "Continuation Coverage under COBRA (COBRA Notice) Section of your SPD immediately following the subsection titled "*Second qualifying event extension of 18-month period of continuation coverage*":

Special rules for health care flexible spending accounts

For a health care flexible spending account (Health FSA), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs. COBRA continuation coverage for the Health FSA cannot be extended beyond that time for any

reason.

EXAMPLE: Assume that an employee elected to contribute a total of $1,200 to her Health FSA account for a Plan Year and then her employment terminates six months after the start of that Plan Year. By that time, she has contributed $600 to her FSA account through payroll deductions. Assume that she has already received $800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is $400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of $588 or less before her employment terminated, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay ($612).

Any filing deadlines or other rules for filing a request for reimbursement under the Health FSA, as described earlier in this Summary Plan Description, will continue to apply if you elect continuation coverage under the Health FSA.

13. Effective April 1, 2018, the Claims Procedures Section of your SPD is replaced in its entirety as follows:

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and for certain medical benefits, the applicable requirements of regulations issued under the Affordable Care Act and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures generally will apply instead of the claims procedures described in this Summary. This Claims Procedure section includes descriptions of the minimum requirements for claims procedures that apply to insured benefits, but full details of claims procedure rules for insured benefits are described in the insurer's Benefit Booklet that describes the specific insured benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims the claims procedures described in this section that apply for benefits other than health or disability benefits will

apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act and, effective for claims filed after April 1, 2018, for purposes of any disability benefits that are subject to ERISA, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a retroactive termination of coverage because of fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a different deadline expressly applies in this Summary or under a Benefits Booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred. (For deadlines for submitting flexible spending account reimbursement requests, see the "Summary of Available Benefits" section of this Summary.)

The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, using the following procedures.

For purposes of these procedures, "health benefit" or "health claim" refer to benefits or claims involving medical, dental, vision or health care flexible spending account coverage. Also, a benefit or claim is considered a "disability benefit" or "disability claim" for purposes of these procedures if the benefit or claim, including claims for accidental death and dismemberment benefits, requires that the Plan or an Insurer make a determination of whether a claimant has experienced a disability.

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. The Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the

Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

(A) For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(B) For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim that is not a pre-service claim).

(c) Disability Benefit Claims. For any disability benefits claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer

expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;

(v) A statement of the Claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial and a description of any time limit that would apply under the Plan for bringing such an action.

In addition, for a denial of health benefits (or disability benefits, if the claim was filed on or before April 1, 2018), the following will be provided to the Claimant:

(vi) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

(vii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

(viii) For an adverse determination concerning an urgent care health claim involving, the notice will also include information about the expedited process that applies to such claims and the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

For any claim for disability benefits (if the claim is filed after April 1, 2018), the notice will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and also will include the following:

(ix) A discussion of the Plan's decision, including an explanation for

disagreeing with or declining to follow:

(1) The views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(x) If the adverse 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, or a statement that such explanation will be provided free of charge upon request;

(xi) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

(xii) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after you receive notice of the initial denial of the claim. The decision on review will be made within a reasonable time but no later than 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for

health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination 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. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage and for claims for disability benefits filed after April 1, 2018 the Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by or on behalf of the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale

for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(B) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within a reasonable time but not later than 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claim for benefits;

(v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA section 502(a) and a description of any time limit that applies under the Plan for bringing such an action (including, for disability benefit claims filed after April 1, 2018, the date that any applicable time limit for bringing such an action would expire);

(vi) if applicable, a statement describing any voluntary appeal procedures offered by the Plan and about the Claimant's rights to obtain information about such procedures

(vii) in addition to items (i)-(vi) above, for any notice of adverse determination regarding health benefits (or disability benefits if the claim was filed on or before April 1, 2018), the following will be provided:

(A) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(B) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request; and

(viii) in addition to items (i)-(vi) above, for claims for disability benefits (filed after April 1, 2018), the notice of Adverse Determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices and will include:

(A) A discussion of the Plan's decision, including an explanation for disagreeing with or declining to follow:

(1) The views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination; or

(3) A Social Security Administration disability determination regarding the Claimant presented to the Plan by the Claimant; and

(B) If the Adverse 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, or a statement that such explanation will be provided free of charge upon request; and

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

Additional Requirements for Medical and Disability Claims

For any adverse determination involving medical coverage, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Also, for all claims involving coverage that is subject to the Affordable Care Act and, effective for claims filed after April 1, 2018, for disability benefit claims, the Plan will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the

determination will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits other than health benefits, the period for making the determination on appeal will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan's Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim involving medical coverage, you will deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the Plan's claim procedures (and applicable regulations unless the Plan's failure to adhere to those requirements is a minor violate (as defined below). If are deemed to have exhausted the Plan's internal claims and appeals process based on the preceding sentence, in addition to the right to pursue any available remedy under ERISA, you will have the right to pursue any remedy under any available external review process provided under federal or state law.

Also, effective for claims for disability benefits filed after April 1, 2018, you will be deemed to have exhausted the Plan's internal claims and appeals process if the Plan (or Insurer) does not strictly adhere to the requirements of applicable requirements of applicable regulation unless the Plan's failure to adhere to those requirements is a "minor violation" (as defined below).

For purposes of this Section, the Plan's failure to satisfy applicable claim procedure regulations is a "minor violation" if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this minor violation exception applies, you may request a written explanation of the violation from the Plan, and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

For claims involving medical coverage, if an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, you will be permitted to resubmit and pursue the

internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon your receipt of the notice.

For claims involving disability benefits, if a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception described above, the claim will be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. In such cases, within a reasonable time after the Plan's receives the decision, the Plan will provide you with notice of the resubmission.

External Review

(a) External Review Process. For purposes of any coverage that is subject to the Affordable Care Act, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

(b) Availability of External Review. External review is not available for all adverse determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage; or

(iii) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

(c) Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

(d) Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice.

(e) Referral to Independent Review Organization. External reviews are conducted by independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will contract with at least three different IROs. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the

Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving 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 adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) The Claimant's medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(D) The terms of the Plan, unless the terms are inconsistent with applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(G) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical

reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;

(F) A statement that judicial review may be available to the Claimant; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(e) Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will provide any benefits (including by making payment on

the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

(a) Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(b) Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

13. The "Non-Assignment of Benefits" Section of your SPD is revised to read as follows:

Non-Assignment of Benefits. Notwithstanding anything contained in any Benefits Booklets, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, including before or after services for the benefit are rendered, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person. Subject to the foregoing, the Administrator shall be permitted, in its discretion, to make a direct payment to a provider of services for which benefits are available under the Plan and such direct payment to the provider by the Plan shall not be considered an assignment or alienation hereunder, and neither the direction by a participant, spouse or dependent to make such payment nor the payment itself shall be interpreted as the Administrator's recognition of the validity of any attempted alienation or assignment of benefits hereunder nor confer on the payee any rights besides the right to receive the payment in the amount of that payment.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for Plan coverage for an Alternate Recipient, in the manner described in ERISA §609(a) and in the Plan's QMCSO Procedures.

14. Any new Benefits Booklets which have been, or will be, distributed to you are part of your SPD.

If you have questions about these Plan changes, this SMM, or your SPD, please contact the Plan Administrator at the following address or phone number:

Gray & Son/Maryland Paving MGMT, Inc.
430 West Padonia Road
Timonium, MD 21093
(410)771-4311

GRAY & SON/MARYLAND PAVING MGMT, INC. GROUP HEALTH PLAN
SUMMARY PLAN DESCRIPTION
Effective April 1, 2016

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GENERAL INFORMATION ABOUT THE PLAN

Name of Plan

Gray & Son/Maryland Paving MGMT, Inc. Group Health Plan

Name and Business Address of Plan Sponsor

Gray & Son/Maryland Paving MGMT, Inc.
430 West Padonia Road
Timonium, MD 21093

Plan Sponsor's Taxpayer Identification Number

52-1899097

Plan Number

501

Type of Administration

The Plan is administered by the Plan Administrator. Please note that participant benefit accounts under the Plan are merely bookkeeping entries, no assets or funds are ever paid to, held in or invested in any separate trust or account, and no interest is paid on or credited to any benefit account. Some benefits may be provided through insurance contracts. To the extent that any benefits are not provided through insurance contracts, they are paid from the Employer's general assets.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and are final and binding on all interested parties. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Health Coverage Insurance and Funding Information

Allegeant, 9475 Deereco Road, Suite 408, Timonium, MD 21093 is the claims processor of your medical benefits under the Plan. The Plan's medical benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance company.

US-Rx Care, 6412 N University Drive, Suite 113, Tamarac, FL 33321 is the claims processor of your prescription drug benefits under the Plan. The Plan's prescription drug benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance company.

United Concordia Companies, Inc., 309 International Circle, Hunt Valley, MD 21030 is the claims processor of your dental benefits under the Plan. The Plan's dental benefits are self-funded obligations of the Employer and are not guaranteed under a policy of insurance issued by any insurance company.

Advantica Eyecare, Inc., 3290 Pine Orchard Lane, Suite D, Ellicott City, MD 21402, is the insurer and claims processor of your vision benefits under the Plan. The Plan's vision benefits are fully guaranteed under the policy of insurance issued by this company.

Affordable Care Act

This Summary includes various provisions that are required to comply with the requirements of the federal health care reform law, (the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010) and with regulations and other guidance issued under that law. Whenever this Summary refers to the "Affordable Care Act" it is referring to the PPACA, as amended, and any applicable regulations. The health care reform requirements of the Affordable Care Act generally apply only to the Plan's medical/prescription drug coverage. When this Summary refers to coverage that is subject to the Affordable Care Act, it means the Plan's medical/prescription drug coverage.

Plan Year

The Plan Year is the period beginning each April 1 and ending each March 31 while the Plan is in effect.

Name, Business Address and Telephone Number of Plan Administrator

Gray & Son/Maryland Paving MGMT, Inc.
c/o Human Resources Department
430 West Padonia Road
Timonium, MD 21093
(410)771-4311

Service of Legal Process

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

Type of Plan

This Plan is a form of employee welfare benefit plan called a "cafeteria plan" because it allows you to choose the benefits you will receive from the Plan. You are given the opportunity to direct the Employer to reduce your salary by a specified amount. You then can use the amount of the salary reduction to purchase benefits under the Plan. For certain benefits, because your salary is reduced before federal taxes (and, in most states, state taxes) are imposed, you pay less in taxes if you participate in the Plan. (Some benefits may require that you make after-tax contributions.)

Eligibility

If you are a full-time regular employee of an Employer (i.e., if you are regularly scheduled to

work at least 30 hours per week, as determined by the Employer), you and your eligible dependents are eligible to participate in the Plan beginning on the day following your completion of 90 days of continuous of employment with the Employer (your "Participation Date"). If you are such an employee your eligibility will continue during the period each year (if any) during which you are on lay-off (see the Termination of Employment section of this SPD for more information). Employer paid long term disability coverage is available only to exempt employees. Employee assistance program (EAP) coverage is available to all employees.

In September 2015, the Employer purchased the assets of Parrott Materials Company, Parrott Equipment Company, and A.G. Parrott Company. If you became an eligible employee of an Employer on the closing date of that asset purchase, you will be given prior service credit toward the waiting period described above for your service with any of the following: Parrott Materials Company, Parrott Equipment Company, and A.G. Parrott Company. If you had already completed more than 90 days of continuous employment at one or more of those companies (as determined by the Employer), you will be immediately eligible to participate in the Plan on the day you become an eligible employee.

For purposes of this continuous employment requirement as it applies to the Plan's health benefits, if you are absent from work because of a health condition, your absence will not interrupt your completion of the continuous employment requirement. That is, any period of continuous service that you complete before your health-related absence will apply toward the continuous employment requirement and will be added to any period of continuous service that you complete after you return to work following your health-related absence.

Leased employees, seasonal employees (as determined by the Employer), persons classified by the Employer as part-time employees of the Employer (as determined by the Employer), and employees covered by a collective bargaining agreement and their dependents (unless Plan participation is provided for in the collective bargaining agreement) are not permitted to participate in the Plan. A person who is not characterized by the Employer as an employee of the Employer, but who is later characterized by a regulatory agency or court as being an employee, will not be eligible for the period during which he or she is not characterized as an employee by the Employer. In addition, if the Employer is or becomes a sole proprietorship, a partnership, a limited liability company, a limited liability partnership or a subchapter S corporation, sole proprietors, partners, limited liability company principals, limited liability partners and S corporation 2% shareholders (as defined under applicable law) of the Employer and their dependents generally are not permitted to participate in the pre-tax salary reduction feature of the Plan.

If your employment terminates while you are a participant in the Plan and you are rehired within 3 months, you will again become a participant in the Plan beginning on your rehire date but if you are rehired after 3 months, you will be treated as a new employee and you will need to satisfy the Plan's eligibility requirements without counting any previous period of employment. However, if you are rehired during the same Plan Year and within 3 months after your previous period of employment ended, you generally will not be permitted to make a new election of benefits, but your previous election of benefits will be reinstated.

Please note that your eligibility for any particular benefit is determined under Plan terms applicable to that benefit. The Benefit Booklets delivered with this Summary include information about any additional or different eligibility requirements that may apply to specific benefits.

The next section describes some eligibility special rules for employees who are not eligible for coverage under the rules described above. If you are eligible for coverage based on the rules above, the rules in the next section will not affect you so you may want to just skip to the "Dependent Eligibility" section

New Additional Eligibility Opportunities

If you do not qualify as an eligible employee based on the rules described in the "Eligibility" section above, you may still become eligible for benefits under the Plan based on new rules that apply in determining if someone is a full-time employee for purposes of the Affordable Care Act.

These rules vary depending on whether you are considered a "new employee" or not. You are considered a new employee until you have been employed for a full "Standard Measurement Period", as described below. Anyone who is not a "new employee" is considered an "ongoing employee".

Measurement Periods for Ongoing Employees

If you are not eligible for coverage based on the rules in the "Eligibility" section, you will be considered a full-time employee for a Plan Year (and eligible for benefits for that Plan Year), if you average at least 30 Hours of Service per week during a 12-month "Standard Measurement Period" that ends shortly before the Plan Year.

The plan uses a Standard Measurement Period lasting from January 2 through the next January 1 and then offers benefits to employees who are determined to be full-time based on that Measurement Period sometime between the end of that period and the start of the next Plan Year (your "Participation Date").

Example: if you average at least 30 Hours of Service per week during the Measurement Period lasting from January 2, 2016 through January 1, 2017, you would be considered a full-time employee for the Plan Year that begins on April 1, 2017 and you would be eligible to elect benefits to be effective starting April 1, 2017. In that case, you would be informed of your eligibility sometime after January1, 2017 and you would be given the opportunity to elect benefits to be effective April 1, 2017.

If you become eligible for benefits based on your hours worked during a Standard Measurement Period, note that you will be eligible only for the next Plan Year following the end of that Standard Measurement Period. To be eligible for future periods, you must again qualify based on hours worked during a later Standard Measurement Period (or based on the rules in the "Eligibility" section).

Measurement Periods for New Employees

Different rules applies for new employees.

If you are not eligible based on the rules described in the "Eligibility" section but on the date you become an employee of the Employer you are reasonably expected to work at least 30 Hours of Service per week for the Employer, and you are not classified as a seasonal employee (as determined by the Employer), you and your eligible dependents are eligible to participate in the Plan beginning

on the day following your completion of 90 days of continuous employment with the Employer (your "Participation Date"). If you become eligible for any benefits based on this paragraph, note that your "Initial Eligibility Period" will begin on your Participation Date and will last until the start of the first Plan Year that begins after you have been employed for a full Standard Measurement Period. To be eligible for any benefits after your Initial Eligibility Period, you must be eligible based on the Measurement Period rules that apply to ongoing employees (or based on the rules in the "Eligibility" section).

If the previous paragraph does not apply, a New Employee Measurement Period applies for any person who has not been employed for a full Standard Measurement Period. For example, if you started work on January 15, 2016, you would be considered a new employee for this purpose until the end of the next 12-month Standard Measurement Period that begins after your start date. The next Standard Measurement Period would start January 2, 2017 so you would be a new employee for this purpose until January 1, 2018.

The New Employee Measurement Period is based on each employee's start date so it is different for each new employee. It begins on the date the employee commences employment and ends 12 months later. If you are a new employee and you average at least 30 Hours of Service per week during your New Employee Measurement Period, you will become eligible to enroll in benefits under the Plan beginning on your Participation Date, which will be the first day of the second month that begins after the last day of your New Employee Measurement Period.

> *For example, if you start work on January 15, 2016, your New Employee Measurement Period would begin on your start date and would end on January 14, 2017. If you average at least 30 Hours of Service per week during your New Employee Measurement Period, you would then be given an opportunity to enroll in the Plan to be effective on March 1, 2017.*

If you become eligible to participate in the Plan based on hours worked during a New Employee Measurement Period, your "Initial Eligibility Period" generally will last no longer than the end of the 12-month period that begins on your Participation Date. However, if your New Employee Measurement Period ends before the start of the first Plan Year that begins after you have completed a full Standard Measurement Period, your Initial Eligibility Period will last until that Plan Year starts. To be eligible for any benefits after your Initial Eligibility Period ends, you must qualify for a later period based on the Measurement Period rules that apply to ongoing employees (or based on the rules in the "Eligibility" section).

An employee or a former employee who returns to work with the Employer after a period of 13 weeks or longer during which he or she was credited with an Hour of Service with the Employer is considered to be a new employee for purposes of the Measurement Period rules.

If you experience a material change in position or employment status, during your New Employee Measurement Period that results in you becoming reasonably expected to work at least 30 Hours of Service per week for the Employer, you will become eligible to enroll in benefits under the Plan beginning on the date that would be your Participation Date under the second paragraph of this *Measurement Periods for New Employees* subsection or, if later, on the date of the change in position or employment status. You will be informed by the Employer if this applies to you.

Calculating Hours of Service

For purposes of these rules, an "Hour of Service" is defined based on IRS regulations and generally includes any hour for which you are paid, or entitled to payment, for performing services for the Employer (or for certain related employers) plus any hour for which you are paid, or entitled to be paid for periods when you are not working, such as for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or other paid leaves of absence.

In determining if an employee averages at least 30 Hours of Service per week during any Measurement Period, certain periods of time are ignored (so that they do not reduce your average). This includes periods of unpaid leave for jury duty, for military service leave that is subject to the federal law known as USERRA and FMLA leave.

In computing your hours of service, for any period when you are not paid on an hourly basis, you will be credited with exactly eight Hours of Service for each day for which you would be credited with at least one Hour of Service.

Because hours are tracked on a payroll period basis and the Plan's Measurement Periods do not always begin on the same date as a payroll period, you will be credited with Hours of Service for a Measurement Period starting on the first day of the pay period that includes the first day of the Measurement Period and ending with the last day of the last pay period that ends on or before the last day of that Measurement Period.

Dependent Eligibility

For purposes of benefits offered under the Plan that allow you to enroll dependents, your *spouse* is considered an eligible dependent (*spouse* and other *italicized* terms used in this section are defined below).

Your *child* is eligible for coverage offered to dependents under the Plan based on the following rules:

1. Medical/Prescription Drug, Dental and Vision Coverage for Children under Age 26. For purposes of medical/prescription drug, dental and vision benefits offered under the Plan, your eligible dependents include your *child* who is under age 26, regardless of the child's marital status, tax dependent status or student status and regardless of whether the child lives with you.

2. Coverage for Children with Disabilities. For purposes of all coverage offered to dependents under the Plan, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable tax year is an eligible dependent if he or she is physically or mentally incapable of self-support, but only if the physical or mental incapacity commenced before the child reached age 26 for medical/prescription drug, dental and vision coverage and, for dependent life insurance coverage, age 21, or while the child was 21 or over but under age 25 and enrolled as a full-time student.

3. Dependent Life Insurance Coverage for Children under Age 26. For purposes of dependent life insurance benefits, your unmarried *child* who is your *dependent for federal income tax purposes* for the applicable tax year is your eligible dependent if he or she is:

$ under age 21; or

$ a full-time student who is at least 21 but under age 25 (to be a full-time student, the child must regularly attend an educational institution that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on).

The following definitions apply for purposes of this Dependent Eligibility section:

Child means a natural child, a legally adopted child who is under age 18 at the time of the adoption, a child placed with you for adoption who is under age 18 at the time of the placement, a foster child (if the child is an "eligible foster child", as defined in the Internal Revenue Code), or a stepchild. *Child* also includes any other person whose welfare is your legal responsibility under a legal guardianship, written divorce settlement, written separation agreement or a court order.

Spouse means a person who is treated as the spouse of the employee under applicable law because of a marriage. The Plan Administrator will determine if a person is an employee's spouse by referring to (and interpreting, in its discretion, as needed) applicable law of the state in which the marriage occurred. Notwithstanding the preceding, for purposes of determining if someone is eligible for coverage as a spouse, the Plan does not recognize common law marriages, regardless of whether the marriage is recognized in any state.

Dependent for Federal Income Tax Purposes

Whether someone is your *dependent for federal income tax purposes* is determined under IRS rules. For details on the requirements for someone to be your federal income tax dependent, see IRS Publication 501 (available online at www.irs.gov/pub/irs-pdf/p501.pdf). Anyone you can claim as your dependent on a federal income tax return will qualify as your *dependent for federal income tax purposes* under the Plan. However, for purposes of this Plan's health benefits, note that even if your family member would not qualify as your dependent for federal income tax purposes under the IRS rules solely because (a) you are a dependent of someone else or (b) he or she has gross income for the year greater than the IRS personal exemption amount (this amount is $4,050 for 2016 and is subject to adjustment for inflation each year), that family member is still considered to be your *dependent for federal income tax purposes* for purposes of the Plan's dependent eligibility requirements.

Also, in determining if your minor or disabled child is your *dependent for federal income tax purposes*, a special rule applies in cases of divorce or legal separation or if you and your child's other parent live apart for all of the last six months of the calendar year if either you or the child's other parent has custody of the child and is actually entitled to claim the child as a dependent for tax purposes. In those cases, as long as at least half of the child's support for the applicable calendar year is being provided by you and the other parent (and your current spouses, if any) together, the child can be considered your *dependent for federal income tax purposes* for purposes of the Plan's health benefits.

A person otherwise qualifying as your eligible dependent will not be covered for any coverage providing benefits to dependents unless you have elected to pay and have paid the required

additional contributions, if any, for dependent coverage. Also, unless otherwise required by law, note that your spouse or child will not qualify as an eligible dependent while on active duty in the armed forces of any country.

You are responsible for determining if someone qualifies as your spouse or dependent for purposes of the Plan's dependent eligibility rules, subject to the Employer's final approval. The Employer may require you to provide proof that an individual satisfies all of the Plan's eligibility requirements. Also, if at any time during a Plan Year your eligible spouse or dependent becomes ineligible for coverage, you are responsible for notifying the Employer of that change in eligibility. If, at any time, the Plan pays benefits for any person you elected to enroll in your coverage who is later determined not to qualify as your eligible dependent, the Plan may recover from you any amounts paid for such benefits, using any recovery means available under applicable law (including, but not limited to, wage garnishment).

If you and your eligible spouse or dependent are both employees of the Employer and each of you meets the Plan's eligibility requirements to participate in the Plan as employees, you may elect employee-only medical/prescription drug, dental or vision coverage or one of you may elect family (or employee and spouse or dependent) coverage. However, no employee can be covered under the Plan's medical/prescription drug, dental and vision coverage as another employee's spouse or dependent at the same time that he or she is also covered under the Plan as an employee/participant.

For purposes of the Plan's medical/prescription drug, dental and vision coverage, if a child would otherwise qualify as a dependent of more than one participant, the child may be treated as the dependent of only one participant. If this applies to you, you and your spouse must decide who will elect coverage for the child.

For any insured coverage offered under the Plan, the terms of the insurance contract, instead of this "Dependent Eligibility" section, will determine whether any person is your dependent for purposes of that benefit. The Benefits Booklets provided to you with this Summary will include any additional or different dependent eligibility requirements that apply for any insured coverage.

All Qualified Medical Child Support Orders that provide Plan coverage for so-called "Alternate Recipients" will be honored by the Plan. (These orders are a type of order by a court or by an administrative agency providing coverage for children of Plan participants.) As required by applicable law, the Plan uses procedures to determine whether a medical child support order is a "Qualified Medical Child Support Order" that must be honored by the Plan. Upon request to the Plan Administrator, you may receive, without any charge, a summary of these procedures.

Participation

(a) Initial Election Period. If you are not already a participant in the Plan, to become a participant on your Participation Date, you must be an active employee of the Employer on your Participation Date and you must properly complete and submit an initial Election Form to the Plan Administrator (or complete a designated electronic enrollment process, if available) before your Participation Date and during the period designated by the Plan Administrator as your initial "enrollment period". For purposes of medical benefits only, you will be treated as an active employee on your Participation Date even if you are absent from work if your absence occurs because of a health condition (as determined by the Employer).

However, if you are an employee who becomes an employee as a result of the asset purchase described in the "Eligibility" section, and you are immediately eligible to participate in the Plan as of the closing date in September 2015, you may complete and submit your Election Form (or complete a designated electronic enrollment process, if available) during your first thirty days of employment and your coverage will be effective retroactive to your Participation Date (the date you were hired).

Your benefit elections made during your initial enrollment period will be effective from your Participation Date until the last day of the Plan Year in which you change your initial benefit election (see subsection (b) below) or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (see subsections (d) and (e) below).

If you fail to properly complete and submit an Election Form to the Plan Administrator during your initial election period, you will automatically receive Employer-paid life insurance/accidental death & dismemberment (AD&D), employee assistance program (EAP), and short term disability coverage but you will not automatically participate in any other feature of the Plan. In addition, exempt employees who are not 2% or more shareholders will automatically receive long term disability coverage.

(b) Election Periods after Initial Election Period. After you complete the initial Election Form, your initial benefit election will remain in effect indefinitely or until you experience a Status Change (see subsection (c) below), exercise a Special Enrollment Period right (see subsection (f) below) or qualify to change your elections for certain other reasons (as described in subsections (d) and (e) below) or until you make a new benefit election by requesting, completing and submitting a new Election Form to the Plan Administrator for a future Plan Year during the period preceding the Plan Year that is designated by the Plan Administrator as the Plan's annual "election period". Your new benefit election will be effective from the first day of the Plan Year following the election period in which you make your new benefit election until you change your election during a later election period, or you experience a Status Change, exercise a Special Enrollment right or otherwise qualify to make an election change that is permitted under the Plan.

Although your benefit elections normally will carryover from one Plan Year to the next as described above, the Employer may announce before the start of a Plan Year that new elections will be required for all eligible employees to participate in benefits for that upcoming Plan Year. In such cases, a special required election period will be announced for all eligible employees to make new elections, which will take effect at the beginning of the next Plan Year. An employee who fails to make an election of available benefits for the following Plan Year during that special required election period will cease to participate in the Plan (except for purposes of any Employer-paid benefits that may be provided automatically without the need for an election, as described in subsection (a) above) at the end of the Plan Year in which the special required election period occurs.

(c) Changes of Election to Reflect Status Change. If you are currently participating in the Plan, you may, with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, change your elections by filing a Status Change Form within 30 days after a Status Change event. If you are not currently a participant in the Plan but you have satisfied all the requirements to be eligible to participate (except that you do not have a current

benefit election in place), with the approval of the Plan Administrator and subject to the requirements described below and any conditions or restrictions that may be imposed by any insurance company providing benefits under the Plan, you may become a participant by filing an Election Form and a Status Change Form within 30 days after a Status Change event occurs.

Under applicable law, to be permitted to make a change in your benefit elections because of a Status Change event, the Status Change event must result in you or your spouse or dependent gaining or losing eligibility for that coverage or similar coverage under the Plan, a plan sponsored by another employer by whom you are employed or a plan sponsored by the employer of your spouse or other dependent.

Any change that you wish to make to your benefit elections also must be consistent with the Status Change event that occurred. The Employer will determine whether, under applicable law, a requested change (or a new election) is consistent with the Status Change you experience. For example, if you become eligible for health coverage offered by your spouse's employer because you get married or because your spouse changes employers, you may cancel your health coverage under this Plan only if you certify to the Employer that you have actually enrolled or intend to enroll in the other Plan. Under applicable law, it would not be consistent with the Status Change if you merely dropped coverage under this Plan without enrolling in the other plan. However, for purposes of group term life insurance, accidental death or dismemberment insurance or disability coverage, any change you wish to make because of a Status Change, such as increasing coverage, decreasing coverage or dropping coverage, will be treated as consistent with the Status Change.

Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the elections are approved by the Plan Administrator, and will be effective until you change your elections according to the Section entitled "Election Periods After Initial Election Period" or you experience another Status Change.

You will experience a Status Change if:

your legal marital status changes including changes because of marriage, the death of your spouse, divorce or legal annulment;

there is an event that causes you to gain or lose a dependent;

you, your spouse or your dependent terminates or begins employment;

there is an increase or reduction in hours of employment (including a switch between part-time and full-time employment, a strike or lockout, or the beginning or ending of an unpaid leave of absence) by you or your spouse or other dependent;

you, your spouse or your dependent becomes eligible or loses eligibility for coverage under a plan offered by that person's employer because of a change in employment status (for example, if your dependent switches from hourly to salaried employment and the dependent's employer's medical plan covers only salaried employees);

an event happens that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or similar circumstance;

there is a change in location of the residence or worksite of you or your spouse or other dependent; or

for any election made on an after-tax basis, you experience any event which, in the Administrator's sole discretion, qualifies as a Status Change.

(d) Changes of Election Because of Changes in Cost or Coverage. You may make certain changes, as described below, because of changes in cost or coverage of benefits available under the Plan. You must request such an election change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion). Generally, your new elections will take effect as soon as practicable after the date you complete and submit the Status Change Form and the Election Form, if required, and the elections are approved by the Plan Administrator, and will be effective until you change your elections according to the Section entitled "Election Periods After Initial Election Period".

The rights described in paragraphs (i)-(iv) below are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan. Also, the rights described in (i)-(iv) below do not apply to elections involving a health care flexible spending account. You may not make an election change for any benefit option because of a change in cost or coverage under a health care flexible spending account maintained by the employer of your spouse or dependent.

(i) Significant Cost Changes. If the amount that you are required to pay for a benefit option significantly increases (as determined by the Employer) while you are covered under that benefit, you may elect to revoke your election for that benefit and elect another similar benefit option, if one is available (as determined by the Employer). If no similar benefit option is available, you may elect to drop your coverage because of the increased cost.

If the amount that you are required to pay for a benefit option significantly decreases (as determined by the Employer) during the Plan Year, you may elect that benefit option for yourself or an eligible spouse or dependent.

You may change your elections because of a significant cost change, as described above, regardless of the reason for the increase or decrease in your cost. It does not matter whether the change in cost results from an action taken by the Employer or if it occurs because of something you do (such as switching from part-time to full-time employment if that changes the amount you have to pay for coverage).

(ii) Coverage Changes. If your coverage under a benefit is significantly curtailed during the Plan Year, you may revoke your election of that benefit and elect another benefit option that offers similar coverage (as determined by the Employer), if any. Coverage is significantly curtailed only if there is an overall reduction of the coverage provided to all participants (as determined by the Employer).

If your coverage under a benefit is significantly curtailed during the Plan Year (as determined by the Employer), and the significant curtailment amounts to a complete loss of coverage (as determined by the Employer), you may change your elections as described in the previous paragraph. In addition, if you experience a complete loss of coverage and no other benefit option that provides similar coverage is available, you may drop the coverage entirely. A loss of

coverage includes, for example, the elimination of a benefit option, the loss of availability of an HMO option in the area where you or your dependent reside, or a loss of coverage for you or a dependent under a health plan option because your expenses exceed an annual limit. The Employer, in its discretion, will determine when a curtailment of a benefit amounts to a complete loss of coverage.

If the Employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year (as determined by the Employer), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

(iii) Changes in Coverage of Dependents Under Other Plans. You may also change your elections to correspond to certain changes made under another employee benefit plan. For example, if your spouse's employer has a cafeteria plan with an election period that is different from this Plan's annual election period, you may change your benefit elections to correspond to the changes elected by your spouse during his or her employer's annual election period. Also, if another employer sponsors a cafeteria plan that allows participants to make changes during a Plan Year, such as the ones permitted by this Plan, and a permitted change under that other plan affects you or your eligible dependent, you may elect changes to your coverage under this Plan, as long as your change corresponds with the change made under that other plan. For example, if your spouse revokes a benefit election for a medical plan offered by his or her employer because of an increase in cost, you could change your elections under this this Plan to elect coverage for your spouse.

(iv) Loss of Other Group Health Coverage. If you or your eligible spouse or dependent loses coverage for any group health coverage sponsored by a governmental entity or an educational institution (as determined by the Employer), you may change your election of benefits to elect coverage for the affected individual.

(e) Other Election Changes. Except as otherwise provided below, if you are entitled to an election change described below, you must request the change within 30 days after your right to change your election arises (as determined by the Plan Administrator, in its discretion).

(i) Orders Requiring Coverage. If you are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires you to provide medical coverage for your child, subject to the Employer's approval, the Plan Administrator may change your health coverage election if the Plan is required by the order to provide such coverage and may change the amount of your salary reduction contributions to cover the cost of such coverage. If your former spouse or another individual is required to provide coverage for your child pursuant to such a judgment, decree or order and you provide evidence to the Employer that such coverage is actually being provided, subject to the Employer's approval, you will be permitted to change your election to stop providing medical coverage for your child.

(ii) Medicare or Medicaid Enrollment. If you or your spouse or dependent becomes enrolled in Medicare or Medicaid, subject to the Employer's approval, you may change your election to cancel or reduce medical coverage for that individual. If you or your spouse or dependent loses eligibility for Medicare or Medicaid, again subject to the Employer's approval, you may change your election to commence or increase medical coverage for that individual.

(iii) Revoking Medical Coverage Because of Reduction in Hours. If you are enrolled in medical coverage under this Plan and you are reasonably expected to average at least 30 hours of service per week (as determined by the Employer) but you experience a change in employment status so that the Employer no longer reasonably expects that you will work an average of 30 or more hours per week (as determined by the Employer), you may change your benefit election to cancel your medical coverage (for you and all covered dependents) to enroll in other medical coverage that qualifies as minimum essential coverage for purposes of the Affordable Care Act (such as coverage under another employer's plan or coverage offered through a state or federal exchange or marketplace) if that new coverage is effective no later than the first day of the second month that begins after your medical coverage under this Plan terminates. To qualify to change your coverage, you must provide a signed statement certifying that that you (and all dependents whose coverage under this Plan is also being terminated) have enrolled in or will enroll in the other coverage by the deadline described in the previous sentence. The Employer, in its discretion, may require additional documentation of the other coverage. Note that this rule applies only to medical coverage (not including any health care FSA) and does not allow you to change your election of benefits for any other coverage offered under the Plan.

(v) FMLA Leave. If you take leave under the Family and Medical Leave Act of 1993 (FMLA), you may make certain election changes that are permitted by the Employer in accordance with the FMLA.

(f) Special Enrollment Periods for Employees and Dependents. If you decline enrollment in the Plan's medical coverage options 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 the Plan's medical coverage if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards 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 in the Plan's medical coverage. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. Also, if you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government agency determines that you are eligible for that financial assistance.

If you are eligible to make a special enrollment election described in this section, you may elect coverage under any medical coverage options for which you are eligible under the Plan. If you are eligible for more than one medical coverage option and you are currently enrolled in one coverage option, you may change to a different medical coverage option that is available to you. Benefits elected during a special enrollment period become effective no later than the first day of the

first month that starts after you properly elect coverage. However, for a special enrollment election based on a birth, adoption or placement for adoption, your coverage would be effective starting on the date of the birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator at the address provided in this Summary.

Termination of Participation

Coverage for a participant generally terminates on the earliest of the following dates:

(a) The day on which the participant terminates employment, except for the EAP benefit which will terminate 36 months after the participant terminates employment.

(b) Except for certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant.

(c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(d) Except to the extent required by law, the day on which the participant reports for active duty as a member of the armed forces of any country.

(e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

Coverage for an eligible dependent of a participant generally terminates on the earliest of the following dates:

(a) The day on which the participant terminates employment, except for the EAP benefit which will terminate 36 months after the participant terminates employment.

(b) Except for certain leaves of absence, the day on which the participant ceases to qualify as an eligible employee of the Employer or a participant.

(c) For any coverage requiring participant contributions, if those contributions are discontinued, the last day of the period for which contributions by the participant are paid.

(d) Except to the extent required by law, the day on which the eligible dependent reports for active duty as a member of the armed forces of any country.

(e) The day on which all benefits, or the applicable benefits, are terminated by amendment of the Plan, by whole or partial termination of the Plan or discontinuation of contributions by an Employer.

(f) The last day of the month in which the eligible dependent ceases to be an eligible dependent.

Coverage under the Plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may occur in only two situations. First, as indicated above, if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the Plan, or makes an intentional misrepresentation of a material fact. In that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

If your coverage terminates under certain conditions, you may have the right to elect continuation coverage for certain benefits offered under the Plan. See the "Continuation and Conversion Rights" and "COBRA Notice" sections of this Summary for more details.

Also, if you take a leave of absence from employment with the Employer because of military service and your health coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue health coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in the COBRA notice section of this Summary and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the date coverage would terminate under the Plan's normal termination provisions for a reason other than your military service (2) the last day of the 24-month period beginning on the date your military leave of absence begins; or (3) the day after the date on which you fail to timely apply for or return to a position of employment with the Employer. Please contact the Employer if you have questions about coverage during periods of military service.

The Plan contains special provisions in the next two paragraphs for continued coverage during certain periods when a participant is not actively at work. In some cases the Affordable Care Act provisions described above in the "Additional Eligibility Opportunities" section may require continued coverage with respect to a participant during a period of short term or long term disability. In those provisions are more generous than the provisions below, the Plan will follow those provisions.

If you are on a leave of absence because of a qualifying disability for up to 26 weeks, your coverage under the Plan's medical, dental and vision coverage will not end because of your leave of absence. Your coverage may end during that period for any reason other than the leave of absence,

including for a failure to pay any required contributions when due. If you do not return to eligible employment after the disability ceases (as determined by the Employer), or, if earlier, after the end of the 26th week of qualifying disability leave, your coverage will end based on the above rules, subject to any COBRA rights or any other provision of this Plan that may provide for continued coverage. Eligibility for continuation of benefits under this provision is dependent upon your compliance with all reasonable requests for documentation of your disability status. To continue your coverage during your disability leave, you must pay any required contributions when due during the leave. If you have questions about paying for coverage during a period of disability leave, please contact the Plan Administrator.

Also, if you are classified by the Employer as being on seasonal layoff for a period of up to 26 weeks, your coverage under any medical, dental and vision coverage offered under the Plan will not end because of your being on seasonal layoff. Your coverage may end during that period for any reason other than the leave of absence, including for a failure to pay any required contributions when due. If your employment permanently terminates during the period of seasonal layoff for any reason (as determined by the Employer), your coverage will end based on the Plan's normal termination of coverage rules instead of this paragraph, subject to any COBRA rights or any other provision of this Plan that may provide for continued coverage. Also, if you do not return to eligible employment on the date you are required to return after being recalled from layoff (as determined by the Employer), or, if earlier, on the next work day after the end of the 26th week of seasonal layoff, you will cease to be an eligible employee on that date and coverage will end in accordance with the Plan's normal termination of participation rules, subject to any COBRA rights or any other provision of this Plan that may provide for continued coverage. If you are expected to be subject to seasonal layoff, your payments for coverage during the period of layoff generally are paid in advance by increasing your contributions for coverage during the period when you are working. If you have questions about paying for coverage during a seasonal layoff, please contact the Plan Administrator.

Summary of Available Benefits

The following benefits are available under the Plan. Any salary reduction contributions you will be required to make to obtain any elected benefit will be determined by the Employer, and will be communicated to you from time to time. Please note that all elections and benefits under the Plan are subject to a number of legal rules. If any of these rules affect you or require a change to your elections or benefits, you will be notified.

Medical/Prescription Drug Coverage. If you are eligible to participate in the Plan, you may purchase medical/prescription drug coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Pediatric vaccine coverage under the Plan will not be less than the Plan's pediatric vaccine coverage, if any, on May 1, 1993. Medical coverage under the Plan will comply with the reconstructive surgery requirements of the Women's Health and Cancer Rights Act of 1998.

Dental Coverage. If you are eligible to participate in the Plan, you may purchase dental coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Vision Coverage. If you are eligible to participate in the Plan, you may purchase vision coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, and will be communicated to you from time to time.

Life Insurance/AD&D Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense life insurance/AD&D coverage and you may purchase voluntary life insurance coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, will be after-tax, and will be communicated to you from time to time.

Spouse Life Insurance Coverage. If you are eligible to participate in the Plan, you may purchase spouse life insurance coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, will be after-tax, and will be communicated to you from time to time.

Dependent Life Insurance Coverage. If you are eligible to participate in the Plan, you may purchase dependent life insurance coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, will be after-tax, and will be communicated to you from time to time.

Short Term Disability Coverage. If you are eligible to participate in the Plan, you will receive at the Employer's sole expense short term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Employee Assistance Program Coverage. All employees will receive at the Employer's sole expense employee assistance program coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary.

Long Term Disability Coverage. If you are an exempt employee eligible to participate in the Plan (other than a 2% or more shareholder), you will receive at the Employer's sole expense long term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. If you are a 2% or more shareholder who is eligible to participate in the Plan, you may purchase long term disability coverage. A detailed description of this coverage appears in the Benefits Booklets delivered to you with this Summary. Any salary reduction contributions you will be required to make to obtain the benefits will be determined by the Employer, will be after-tax and will be communicated to you from time to time.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends. In addition, if any of your health care benefits are provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your health care continuation or conversion rights, please contact the Plan Administrator.

Also, please review the next section regarding continuation coverage under the federal law known as "COBRA".

Continuation Coverage Under COBRA (COBRA Notice)

This "COBRA Notice" section of your Summary Plan Description applies to employees and covered spouses and dependents who have health coverage under the Plan. For purposes of this notice, "Plan" refers only to the medical/prescription drug, dental, vision and EAP benefits described in this Summary and this notice is not intended to apply to any other type of benefit.

You are receiving this notice because you are covered under a group health plan offered under the Plan. This notice contains important information about your right 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.** Both you and your spouse (if you are married and your spouse is covered by the Plan) should take the time to carefully read this notice.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator at the address provided in this notice.

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 health coverage under the Plan when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

- 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 any of the following qualifying events happens:

- 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."

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 or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You must give notice of some qualifying events.

For the other qualifying events (<u>divorce</u> or <u>legal separation</u> of the employee and spouse or a <u>dependent child's losing eligibility for coverage</u> as a dependent child), you must notify the Plan Administrator within 60 days after the later of (1) the date the qualifying event occurs or (2) the date coverage would end because of the qualifying event. This notice must be provided, along with any required documentation to:

Gray & Son/Maryland Paving MGMT, Inc.
c/o Human Resources Department
430 West Padonia Road
Timonium, MD 21093

Your notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- Your name, address, phone number and health plan ID number.
- The name, address, phone number and health plan ID number for any dependent or spouse whose eligibility is affected by the qualifying event.
- A description of the qualifying event and the date on which it occurred.
- The following statement: "By signing this letter, I certify that the qualifying event described

in this letter occurred on the date described in this letter."

- Your signature.

You should also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date the divorce or legal separation began. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided in this notice.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, you may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as described in the next two sections of this Notice.

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. To notify the Plan Administrator of a disability determination, you should follow the same procedures described above under "*You Must Give Notice of Some Qualifying Events*". Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the

date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event. However, regardless of the deadline described in the previous sentence, your notice must be provided no later than the date your COBRA coverage would terminate if you failed to qualify for a disability extension.

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 notice of the second qualifying event is properly given to the Plan (following the same procedures described above under "*You Must Give Notice of Some Qualifying Events*"). 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.

Additional continuation coverage election period for "TAA-eligible individuals"

In addition to the other COBRA rules described in this section of your Summary Plan Description, there are some special rules that apply if you are classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if you qualify for assistance under the Trade Adjustment Assistance Reform Act of 2002 because you become unemployed as a result of increased imports or the shifting of production to other countries.)

If you are classified by the Department of Labor as a TAA-eligible individual, and you do not elect continuation coverage when you first lose coverage, you may qualify for an election period that begins on the first day of the month in which you become a TAA-eligible individual and lasts up to 60 days. However, in no event can this election period last later than six months after the date of your TAA-related loss of coverage. If you elect continuation coverage during this special election period, your continuation coverage would begin at the beginning of that election period, but, for purposes of the required coverage periods described in this Notice, your coverage period will be measured from the date of your TAA-related loss of coverage.

Are there other coverage options besides COBRA continuation coverage?

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

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 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.

Keep your Plan informed of address changes

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

If you have questions or need more information about COBRA continuation coverage under the Plan, please contact the Plan Administrator at the address or phone number provided in this Summary.

Emergency Medical Care

If you believe you need emergency medical care, you should not forego that care because you believe it will not be covered by the Plan.

Patients to Evaluate Care

The Employer assumes no responsibility for the medical care reimbursed by the Plan which is provided by any practitioner. Each patient should evaluate the quality of care and act accordingly. No Plan provision expressed in this Summary or the Plan documents should be interpreted to restrict the access to or delivery of medically necessary services. A patient's decision to forego such care should not be based on his or her interpretation of this Summary Plan Description or the Plan documents.

Health Information Privacy

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. If you are an employee and you are covered under any of the Plan's health benefit options, you should have received a copy of the Plan's Privacy Notice with this Summary (if you did not previously receive one). In addition, a copy of the Plan's current Privacy Notice is always available upon request. Please contact the Plan Administrator at the address indicated later in this Summary if you would like to request a copy of the Notice or if you have questions about the Plan's privacy policies.

Medical Benefits Following Childbirth

The Plan and any health insurance company insuring health benefits under 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 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 and/or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, the Plan and any health insurance company may not, under federal law require that a provider obtain authorization from the Plan or health insurance company, if any, for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

Claims Procedures

The following summary of the Plan's claims procedures is intended to reflect the Department of Labor's claims procedures regulations and for certain medical benefits, the applicable requirements of regulations issued under the Affordable Care Act and should be interpreted accordingly. If there is any conflict between this summary and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the Plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures will apply instead of the claims procedures described in this Summary. The insurer's claims procedures are described in the Benefits Booklet that describes the specific benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the Plan that is not subject to ERISA, the Department of Labor's regulations do not apply. For those claims, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the Plan Administrator (or an insurer) provide notice to a claimant about any right under ERISA will not apply to such a claim.

To receive Plan benefits, you must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to you. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Adverse Determination

For purposes of this Claims Procedure section, an "adverse determination" is any denial, reduction, or termination of, or a failure by the Plan to provide or make payment (in whole or in part) for, a benefit, including any such decision that is based on a determination of an individual's eligibility to participate in a benefit under the Plan. For any coverage that is subject to the Affordable Care Act, "adverse determination" also includes any rescission of coverage. A rescission of coverage generally is a retroactive termination of coverage because of fraud or for misrepresentation of a material fact. Note that a termination of coverage for failure to pay any required contributions is not considered a rescission and is not subject to these claims procedures even if it is effective retroactive to the date through which coverage was paid for. Whether a termination of coverage is considered a "rescission" and is therefore an adverse determination that is subject to these claims procedures will be determined by the Reviewer based on applicable law.

Initial Claims

Initial claims for Plan benefits are made to the Plan Administrator or, if the benefit is insured, to the Insurer providing that benefit. The remainder of these procedures uses the term "Reviewer" to refer to either the Plan Administrator or the Insurer, whichever is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described below), to the Reviewer. Claims should be submitted promptly after an expense is incurred. Unless a later deadline expressly applies in this Summary or under a benefits booklet or insurance contract, no initial claim for any benefit will be accepted, processed or paid for any expense if the initial claim is submitted later than one year after the date the expense was incurred.

The Reviewer will review the claim itself or appoint an individual or an entity to review the claim, following the following procedures. (For purposes of these procedures, "health benefits" or "health claims" refers to benefits or claims involving medical, dental, vision or health care flexible spending account coverage.)

(a) Non-Health and Non-Disability Benefit Claims. For any claim that is not a health claim or a disability claim, the Claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the 90-day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

(b) Health Benefit Claims.

(i) Urgent Care Claims. If the Claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In cases where the Claimant fails to provide sufficient information to decide the claim, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. For any claim for benefits under coverage that is subject to the Affordable Care Act, the Plan will defer to a determination, if any, by a qualified attending provider that a claim qualifies as an urgent care claim based on the definition summarized in the preceding sentence.

(ii) Concurrent Care Claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Reviewer will notify the Claimant of the adverse determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(iii) Other Health Benefit Claims. For any health benefit claim not described above:

(A) For any pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 15 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 30 days after receiving the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(B) For any post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 30 days after the Plan receives the claim, of those special circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond 45 days after receiving the claim. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services or other benefits already provided (or any other health benefit claim that is not a pre-service claim).

(c) Disability Benefit Claims. For any disability benefits claim, the Reviewer will notify the Claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within 45 days after the Reviewer receives the claim, of those special circumstances and of when the Reviewer expects to make its decision but not beyond 75 days. If, before the end of the extension period, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Reviewer notifies the Claimant of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

(d) Manner and Content of Denial of Initial Claims. If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:

(i) A description of the specific reasons for the denial;

(ii) A reference to any Plan provision or insurance contract provision upon which the denial is based;

(iii) A description of any additional information that the Claimant must provide in order to perfect the claim (including an explanation of why the information is needed);

(iv) Notice that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial;

(v) A statement of the Claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial and a description of any time limit that would apply under the Plan for bringing such an appeal.

In addition, for a denial of health benefits or disability benefits, the following will be provided to the Claimant:

(i) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and

(ii) If the adverse determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances (or a statement that the same will be provided upon request by the Claimant and without charge).

For an adverse determination concerning a health claim involving urgent care, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

Reviews of Initial Adverse Determinations

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

(a) Non-Health and Non-Disability Benefit Claims. For benefits other than health and disability benefits, a request for review of a denied claim must be made in writing to the Reviewer within 60 days after receiving notice of the initial denial of the claim. The decision on review will be made within 60 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The Reviewer will provide the Claimant an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(b) Health and Disability Benefit Claims. A Claimant whose initial claim for health or disability benefits is denied may request a review of that denial no later than 180 days after the Claimant receives the notice of an adverse determination. Except as provided below for an expedited review of a denied urgent care health claim, a request for review must be submitted to the Reviewer in writing.

A Claimant may request an expedited review of a denied initial urgent care health claim. Such a request may be made to the Reviewer orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

In addition to providing the right to review documents and submit comments as described in (a) above, a review will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination 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. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

(iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review determination, without regard to whether the advice was relied upon in making the review determination.

(iv) For purposes of any medical coverage that is subject to the Affordable Care Act, the Plan will allow a Claimant to review the claim file and to present evidence and testimony and will comply with the following additional requirements:

(A) The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and

(B) Before the Plan issues a final decision on review based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of a final denial of a claim (as described in these claims procedures and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) Deadline for Review Decisions.

(i) Urgent Health Benefit Claims. For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of the initial adverse determination by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

(ii) Other Health Benefit Claims.

(A) For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the Claimant's request for review of the initial adverse determination.

(B) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the Claimant's request for review of the initial adverse determination

(iii) Disability Benefit Claims. For disability claims, the decision on review will be made within 45 days after the Reviewer's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 90 days after receipt of a request for review.

(d) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial claim determination, the Reviewer will provide the Claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

(i) a description of its decision;

(ii) a description of the specific reasons for the decision;

(iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;

(iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claim for benefits;

(v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA section 502(a) and a description of any time limit that would apply under the Plan for bringing such an appeal;

(vi) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge upon request; and

(vii) if the adverse determination on review is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

Additional Requirements for Medical Plans

For any adverse determination involving medical coverage that is provided under a plan that is subject to the Affordable Care Act, any notice of an adverse determination will be provided in a culturally and linguistically appropriate manner in accordance with applicable law regarding such notices and will include (in addition to other requirements described above):

(1) information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and

(5) a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Also, for all claims involving coverage that is subject to the Affordable Care Act, the Plan

will ensure that claims and appeals are decided in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of Time Periods

For purposes of the time periods specified in this Claims Procedures section, the period during which a benefit determination must be made begins when a claim or appeal is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a Claimant fails to submit all information necessary for an initial claim for health benefits (other than urgent care benefits) or for disability benefits, the period for making the determination will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds. Also, if a time period is extended because a Claimant fails to submit all information necessary for an appeal of an adverse determination for benefits other than health benefits, the period for making the determination on appeal will be "frozen" from the date the notice requesting additional information is sent to the Claimant until the day the Claimant responds.

Claimant's Failure to Follow Procedures

A Claimant must follow the claims procedures described above to be entitled to file any legal action for benefits under the Plan (unless the Plan fails to follow those procedures).

Plan's Failure to Follow Procedures

If the Plan fails to substantially follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For any claim for benefits under coverage that is subject to the Affordable Care Act, you are deemed to have exhausted the Plan's internal claims and appeals process if the Plan fails to strictly adhere to the applicable requirements of the U.S. Department of Labor's claims procedure regulations (or corresponding regulations issued by the Department of the Treasury or the Department of Health and Human Services), except for certain minor violations. For this purpose, the Plan's failure to comply with the claims procedure regulations is considered a minor violation if (i) the violation does not cause, and is not likely to cause, prejudice or harm to you, (ii) the violation was for good cause or due to matters beyond the control of the Plan, (iii) the violation occurred as part of an ongoing, good faith exchange of information between the Plan and you and (iv) the violation is not part of a pattern or practice of violations by the Plan. If an issue arises regarding whether this "minor violation" exception applies, you may request a written explanation of the violation from the Plan and the Plan will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the Plan's internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the minor violation exception, you will be permitted to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan will provide you with notice of the opportunity to resubmit

and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run when you receive the notice.

In cases where you are deemed to have exhausted the Plan's internal claim procedures, you have the right to pursue any available remedy under ERISA and, if the claim involves coverage that is subject to the Affordable Care Act, you have the right to pursue any remedy under any available external review process provided under federal or state law in accordance with the Affordable Care Act.

External Review

(a) External Review Process. For purposes of any coverage that is subject to the Affordable Care Act, the Plan or Insurer will comply with the applicable requirements of an external review process that applies under federal or state law. For such coverage that is self-funded, unless the Plan is eligible for and elects to participate in a different external review process that is available under federal or state law and that is considered adequate for purposes of the Affordable Care Act, the Plan will comply with the interim procedures for federal external review in Department of Labor Technical Release 2010-01, as modified by Technical Release 2011-02, as summarized in this Section, until those procedures are replaced by other guidance. The Plan will begin complying with any new requirements for external review guidance on or before the date that those requirements become applicable to the Plan.

(b) Availability of External Review. External review is not available for all adverse determinations. For example, external review is not available for an adverse determination based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan. External review is available only for:

(i) any final internal adverse determination (or an initial internal adverse determination on an urgent care claim that qualifies for the expedited external review described below) that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that a treatment is experimental or investigational), as determined by the external reviewer;

(ii) any final internal adverse determination that involves a rescission of coverage; or

(iii) Any other final adverse determination that is eligible for external review in accordance with applicable guidance (as determined by the Plan at the time of the request for external review).

(c) Request for External Review. A request for external review must be submitted to the Plan no later than four months after the Claimant receives notice of an adverse determination for which external review is available.

(d) Preliminary Review. Within five business days after the date the Plan receives a request for external review, the Plan will complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, for a post-service claim, was covered under the Plan at the time the health care item or service was provided;

(ii) The adverse determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(iii) The Claimant has exhausted the plan's internal appeal process (or whether the Claimant is not required to exhaust the internal appeals process under applicable regulations); and

(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after the Plan completes the preliminary review, the Plan will issue a notice in writing to the Claimant. If the request is complete but is not eligible for external review, the notice will describe the reasons external review is not available and, if applicable, will include contact information for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information or materials needed to make the request complete and the Plan will allow the Claimant to perfect the request for external review within the four-month filing period or, if later, within the 48 hours after the Claimant receives the notice.

(e) Referral to Independent Review Organization. External reviews are conducted by independent review organizations. The Plan will assign each external review to an independent review organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Plan will contract with at least three different IROs. The Plan will take action against bias and to ensure the independence of each IRO and will rotate review assignments among them (or the Plan will incorporate other independent, unbiased methods for selection of IROs, such as random selection, and will document such methods). No IRO will be eligible for any financial incentives from the Plan or the Employer based on the likelihood that the IRO will support the denial of benefits.

Under a contract between the Plan and the IRO, the IRO that handles external reviews and the Plan are required to comply with the following external review requirements:

(i) The IRO will consult with legal experts where appropriate to make coverage determinations under the Plan.

(ii) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit additional information in writing to the IRO within 10 business days following the date the Claimant receives the notice. The IRO must consider such additional information in conducting the external review if timely submitted and may, but is not required to accept and consider additional information submitted after 10 business days.

(iii) Within five business days after the date the review is assigned to the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse determination under review. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents

and information, the IRO may terminate the external review and make a decision to reverse the adverse determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.

(iv) After receiving 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 adverse determination that is under review but any reconsideration by the Plan will not delay the external review. The external review may be terminated in such cases only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the IRO. The IRO must terminate the external review upon receiving the notice from the Plan.

(v) The IRO will review all information and documents timely received. In reaching a decision, the IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(A) The Claimant's medical records;

(B) The attending health care professional's recommendation;

(C) Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating provider;

(D) The terms of the Plan, unless the terms are inconsistent with applicable law;

(E) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;

(F) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(G) The opinion of any clinical reviewer for the IRO after considering the information or documents available to the clinical reviewer that the clinical reviewer considers appropriate.

(vi) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.

(vii) The IRO's notice will include:

(A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding

meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(B) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;

(F) A statement that judicial review may be available to the Claimant; and

(G) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PPACA.

(viii) The IRO must maintain records of all claims and notices associated with the external review process for six years following the date of its final decision. An IRO must make such records available for examination by the Claimant, Plan, or a state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(e) Effect of External Review Decision. An external review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding does not preclude the Plan from making payment on the claim or otherwise providing benefits at any time. Upon receiving a notice of a final external review decision reversing an internal adverse determination, the Plan will provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited External Review

(a) Availability of Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives an adverse determination that otherwise qualifies for external review (as described above) and that is:

(i) An adverse determination that involves a medical condition of the Claimant for which the time frame for completing an expedited internal appeal under the Plan's normal procedures for urgent care claims would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) A final adverse determination, if the Claimant has a medical condition where the timeframe for completing a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the

final internal Adverse determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

(b) Procedures for Expedited External Review.

(i) In General. The normal procedures for external review (as described above) apply to expedited external review except as otherwise provided in this section.

(ii) Preliminary Review. Immediately upon receipt of a request for expedited external review, the Plan must determine whether the request is eligible for standard external review. The Plan will immediately send the Claimant a notice of its eligibility determination that meets the preliminary review notice requirements described above.

(iii) Referral to IRO. Upon a determination that a request is eligible for external review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse determination that is being reviewed to the IRO electronically or by telephone or facsimile or any other available expeditious method.

(iv) Notice of Final External Review Decision. The Plan's contract with the IRO will require the IRO to provide review as expeditiously as the Claimant's medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO will be required to provide written confirmation of the decision to the Claimant and the Plan.

Insured Benefits and State Law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Termination or Amendment of Plan

The Plan Sponsor expects to maintain the Plan indefinitely as a program of employee benefits. However, the Plan Sponsor has the right, in its sole discretion, to terminate or amend any provision of the Plan at any time. Therefore, no Plan participant (including any future retiree or retiree who has already retired) has a right to the continued enjoyment of any particular benefit under the Plan after a Plan termination or amendment affecting those benefits.

No Right to Continued Employment

No provision of the Plan or this Summary shall be interpreted as giving any employee any

rights of continued employment with the Employer or in any way prohibiting changes in the terms of employment of any employee covered by the Plan.

Non-Assignment of Benefits

Except as may be required pursuant to a "Qualified Medical Child Support Order" that provides for Plan coverage for an alternate recipient, no participant or beneficiary may transfer, assign or pledge any Plan benefits. This provision will override any conflicting provision(s) found in any Benefit Booklet.

Coordination of Benefits

The coordination of benefits provisions described in the Benefits Booklets delivered to you with this Summary, as interpreted by the Plan Administrator (or insurer, if applicable) in its discretion, control all coordination of benefits situations involving the Plan and other payers.

Subrogation/Right of Reimbursement

As a condition to receiving medical, disability or any other benefits under the Plan, covered persons, including all dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person receives any recovery, by way of judgment, settlement or otherwise, from another person, organization or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing overage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole", the "common fund" doctrine or other similar common-law subrogation rules or legal theories.

Also, each participant and each covered person, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan with respect to any amount that is subject to this subrogation provision, agrees as follows:

(1) The participant and each covered person (or their attorneys or other authorized representatives) will promptly inform the Plan of any settlement agreement and to provide reasonable advance notice of any plans for the disbursement of any settlement funds to the participant or covered person (or to any other person on behalf of the covered person);

(2) The participant and each other covered person (or their attorneys or other authorized representatives) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan under this subrogation provision are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under this subrogation provision);

(3) The participant and each other covered person (or their attorneys or other authorized representatives) will maintain and treat any settlement funds received by or on their behalf, as Plan assets, to the full extent of any benefits paid by the Plan with the participant or other covered person being a trustee of Plan assets with respect to such amounts until the covered person's obligations under this subrogation provision are satisfied; and

(4) The participant and each other covered person (or their attorneys or other authorized representatives) agree that the Plan has an equitable lien on any settlement funds payable to or on behalf of the participant to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under this subrogation provision are satisfied in full.

Insurance Contracts

The Employer may contract with one or more insurance companies for insured benefits to be provided under the Plan. The Employer has the right to replace any such insurance companies from time to time for any reason. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contract used to provide benefits are the property of the Employer, except to the extent, if any, that the Plan Administrator determines that a portion of the amount payable is required to be treated as an asset of the Plan. Any portion of such a payment that is required under applicable law to be treated as a Plan asset may be used to provide or pay for benefits for eligible employees or to pay reasonable Plan expenses or may be used or paid in any other manner that is consistent with applicable law regarding the use of Plan assets.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to the following rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA):

- You can examine, free of charge, at the Plan Administrator's office and at other locations, all of the Plan documents, including insurance contracts, if any, collective bargaining agreements and copies of all documents filed by the Plan (such as detailed annual reports) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- You can obtain copies of all Plan documents governing the operation of the Plan, by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

- In some cases, the law may require the Plan Administrator to provide you with a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA. As described above, if your claim for a Plan benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial, and you have the right to obtain copies of documents relating to the decision, without charge and have the Plan review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials from the Plan and do not receive them within 30 days, you may file suit in 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 after review and reconsideration by the Plan or is ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof considering the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse Plan funds, if any, 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.

You may have the right to continued health 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. You should review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, 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.

Further Information

If you have further questions regarding the Plan or this Summary Plan Description, please contact the Plan Administrator at (410)771-4311.

DEFINITIONS

Definitions: The following descriptions and definitions of medical terminology and plan benefits may be applicable to certain provisions or benefits described in this Summary Plan Description. All benefits are subject to medical necessity, general exclusions and limitations, or other provisions of the plans.

Accident

An unforeseen and unplanned event or circumstance resulting in an Injury.

Ambulatory Surgical Center

A clinic or other establishment licensed and approved by Medicare (where applicable) to perform outpatient surgery, diagnosis and treatment of Illness or Injury on an outpatient basis.

Birthing Facility

A specialized free-standing facility for child-birth which is licensed under applicable law.

Claim Administrator

The person or entity, if any, to whom the Plan Administrator delegates claim administration including, but not limited to responsibility for:

a. receiving and reviewing claims for Plan benefits;
b. determining benefit amounts payable;
c. disbursing benefit payments;
d. reviewing denied claims; and
e. processing appeals under applicable law as described in the Summary Plan Description

under the terms and conditions of a written agreement with the Plan Administrator. The Claims Administrator is Allegeant.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Copayment

The amount the Covered Person is required to pay toward the payment of expenses for which coverage is available under the Plan as specified in the Schedule of Benefits. A Copayment is expressed as a flat dollar amount.

Coinsurance

The amount the Covered Person is required to pay toward the payment of expenses for which coverage is available under the Plan as specified in the Schedule of Benefits. Coinsurance is expressed as a percentage of covered charges.

Covered Services

The Plan's allowable amount for Medically Necessary healthcare services or supplies provided by a certified or licensed provider under the Plan. Covered Services are limited to actual expenses incurred for a healthcare service or supply, subject to general exclusions or limitations herein described in the Summary Plan Description, and after application of any discounts or adjustments from preferred providers.

Covered Person

A person who has satisfied the requirements for becoming a Participant and such person's eligible Dependents, in each case on and after Plan participation has become effective for each such person. Covered Person includes individuals who are covered under a COBRA continuation provision.

Deductible

The Deductible is the amount a Covered Person must pay to service providers out of his or her own funds before certain benefits under the Plan begin. Some benefits require no Deductible while other benefits are subject to Deductibles.

Patient Copayments and Coinsurance payments (i.e., your percentage or share of expenses) do not apply toward the Deductible.

Dependent

See Eligibility section.

Durable Medical Equipment

Medical equipment (e.g., Hospital beds, wheelchairs, etc.) which:

1. is medically necessary and prescribed by a licensed Physician
2. can withstand repeated use;
3. is primarily and customarily used to serve a medical purpose, such as treatment of an illness or injury, improvement of a malformed body member, or prevention of deterioration of the patient's medical condition;
4. is generally not useful to a person in the absence of an Illness or Injury;
5. is appropriate for use in the home; and
6. is not primarily for the convenience of the patient.

All requirements of the definition must be met before an item can be considered Durable Medical Equipment.

Emergency Accident/Illness

Facility and Professional Provider services and supplies for treatment of a sudden and serious onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention, as a prudent lay person would determine under similar circumstances, could reasonably result in:

1. permanently placing the Covered Person's health in jeopardy, thereby causing other serious medical consequences, or

2. causing serious impairment to bodily functions, or

3. causing serious permanent dysfunction of any body organ or part

Employer/Plan Sponsor

The term "Plan Sponsor" refers to Gray & Son, Inc. and Gray & Son/Maryland Paving Management, Inc., which sponsors the Plan and is also the Employer.

Experimental or Investigational

A drug, device, medical treatment or procedure is experimental or investigational:

1. If the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

Fee Schedule

Reimbursement determined and used by the Network for their Providers.

Freestanding Dialysis Facility

A Freestanding Dialysis Facility which is licensed and approved by Medicare (where applicable) and which is primarily engaged in providing dialysis treatment to patients on an out-patient or home care basis.

Home Health Care

Services and supplies provided in the Covered Person's home ordered by a Physician, in lieu of hospitalization, and provided by someone other than a relative or by someone living in the Covered Person's household. The Claim Processor will determine on a case-by case basis whether services and supplies qualify as Medically Necessary Home Health Care expenses by qualifying as one of the following:

1. Brittle diabetics or complications of diabetes requiring professional assessment.

2. Post-operative with sutures, dressings, or complex treatments requiring professional assessment every 24 hours.

3. Receiving chemotherapy as an alternative to hospitalization.

4. Respiratory therapy - including positive pressure or oxygen (not self-administered) requiring professional assessment.

5. Suctioning/Posturing requiring professional assessment.

6. Receiving intravenous fluid or IV drug therapy as an alternative to hospitalization.

7. Decubitus care and other special skin treatment that require professional assessment every 24 hours.

8. Intensive physical/occupational therapy as an alternative to Skilled Nursing Facility care until such time the patient is able to receive services in an outpatient facility.

9. Special observation, frequent monitoring and administration of medications requiring professional assessment.

10. Acute special health monitoring, e.g. uterine monitoring.

11. Terminal, comatose or dehydrated patient, e.g. Hospice.

12. Intravenous feedings.

13. Tracheotomy care.

14. Professional assessment and instruction related to:

    - Medication compliance
    - Home equipment instructions
    - Evaluation of home environment for safety issues

15. Other Illnesses not mentioned above but requiring skilled nursing for homebound patients.

A simple Home Health Care visit shall not exceed 4 hours in duration. Please refer to the Covered Medical Expenses section in the Schedule of Benefits.

Hospice

A special program of care for a terminally ill patient diagnosed to have six months or less to live.

Hospice Care

Healthcare services or supplies provided to a terminally ill Covered Person in the Covered Person's home, a Hospital, a Skilled Nursing Care Facility or other licensed institution to provide Home Health Care, Hospital Care, medical care, nutrition counseling and specialty foods. Hospice Care also shall include bereavement counseling sessions per immediate family member rendered within 6 months following the terminally ill Covered Person's death provided by a licensed Mental Health Provider or pastoral counselor.

Hospital

Any institution for care of the sick or injured which is licensed to operate as such, and which has nurses on duty 24 hours a day, a Physician on call at all times, and facilities for diagnosis of sickness and for major surgery.

Hospital does not include a home for long-term, convalescent, nursing, custodial or domiciliary care; and infirmary, orphanage, or sanatorium, school, home for the needy or aged, or similar institution, a health resort or residential treatment center.

Illness

A sickness or disease including all related conditions and recurrences. Illness also includes pregnancy, miscarriage, childbirth and all related conditions, chemical detoxification and psychiatric conditions.

Injury

An Accident to the body by external force which requires medical or surgical treatment.

Medically Necessary (or Medical Necessity)

A Medically Necessary item or service is an item or service which:

1. provides for the diagnosis, prevention, or care of a covered medical condition; and

2. is appropriate for the symptoms and provides for the diagnosis or treatment of the Covered Person's medical condition; and

3. is supplied or performed in accordance with current standards of medical practice within the United States of America; and

4. is not primarily for the convenience of the Covered Person or the Covered Person's facility or Professional Provider; and

5. is the most appropriate supply or level of service that safely can be provided; and

6. is recommended or approved by the attending Professional Provider.

Medically Necessary items or services do not include Experimental/Investigational items or services.

For diagnostic services to be considered Medically Necessary, the results must be used in making treatment decisions or directing further diagnostic work up.

Mental Health Provider

An individual:

1. licensed or certified to practice psychiatry or clinical psychology; or

2. with a master's degree in social work who is duly licensed as a clinical social worker; or

3. licensed or certified as an addiction counselor, professional counselor, or nurse specialist; or

4. a social worker if a Physician has referred the Covered Person for such treatment; or

5. licensed in a state where he or she is practicing to perform individual/group counseling.

Mental Health Treatment

Healthcare services and supplies provided by a Mental Health Provider to treat a clinically significant mental or emotional disease or disorder that is identified in the most recent edition of the International Classification of Diseases or the Statistical Manual of the American Psychiatric Association.

Morbid Obesity

A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or has a body mass index (BMI) of 40 or more (35 with certain comorbid conditions).

The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

Network

A system of care consisting of Professional Providers and facilities who have agreed with the Employer/Plan Sponsor, Plan Administrator or Claim Processor to provide care to Covered Persons in a manner that seeks to ensure quality of care and appropriateness and cost-efficiency of the care's delivery.

Network Provider

A Professional Provider classified by the Plan as a Network Provider and which may be included in the most current Provider Directory or Addendum. The Plan Administrator is not responsible for any Covered Person's decision to receive treatment, services or supplies from a Network Provider, nor does the Plan Administrator make any warranties or representatives regarding the quality of treatment, services or supplies provided by a Network Provider.

Out-of-Pocket Maximum ("OOP")

The annual limit of a Covered Person's out-of-pocket payments for Covered Expenses in a "Benefit Year" (i.e., a time period to be determined by the Plan Administrator) under the Medical Plan, as specified in the Schedule of Benefits. Any penalties assessed by the Plan, any expenses in excess of the Usual and Customary allowable fees, expenses which are not Medically Necessary, and all expenses which are excluded from coverage by the Plan will not apply towards the OOP. Upon attaining this OOP limit, the Plan will pay 100% of all other Covered Expenses incurred during the "Benefit Year".

Out-of-Network Provider

An Out-of-Network Provider is a Professional Provider who is not a Network Provider.

Penalty

A reduction in Covered Benefits because of failure to request Pre-Certification for hospital admissions and other designated services as well as failure to respond or participate to the Patient Advocate Program. Penalty amounts assessed by the Plan are indicated in the Patient Advocate Program section. Penalties assessed will not be applied to the OOP maximum.

Physician

A person licensed to practice medicine or perform surgery or a licensed practitioner (including a nurse practitioner or Physician assistant) providing healthcare services or supplies if such services are directed and supervised by a Physician.

Plan Administrator

The Plan Administrator is the Employer

Plan's Allowable Amount

When the Plan determines the Allowable Amount for reimbursement under the Schedule of Benefits, it will consider the lesser of: (1) the usual and customary rate, (2) the allowable charge specified under the terms of the plan, (3) the negotiated rate established in a contractual arrangement with a provider or provider network, or (4) the actual billed charges for the covered services.

Pre-Authorization

A process used to confirm whether a proposed service or procedure is approved or disapproved for benefits based on Medical Necessity. A verbal or written authorization is provided. Pre-Authorization may also include specific allowances for the services and contractual limitations. It does not meet Pre-certification requirements.

Pre-Certification

A cost containment program that requires collecting information prior to an inpatient admission and selected outpatient procedures/services to be certified in advance for Medical Necessity; covered for the proposed length of stay (if applicable) and schedule for concurrent review if necessary. This should not be used as a Pre-Authorization for Surgical Procedures.

A reference used for pre-admission review.

Pre-Notification

A process used to notify the Claims Administrator (Allegeant) of selected outpatient procedures/services to be rendered so the administrator can provide direction or information relevant to the processing of services under the Plan.

Preferred Provider Organization (PPO)

See Network and Network Provider definitions.

Prescription Drug means:

1. legend proprietary (brand name) and generic drugs; and

2. other state-controlled drugs, which, by law, must be Physician-prescribed.

Primary Care Physician ("PCP")

Any duly licensed doctor who is engaged in the practice of family medicine, general practice, internal medicine, pediatric medicine and geriatric medicine and/or who is classified as a Primary Care Physician by the Plan.

Professional Provider

Any Hospital, Skilled Nursing Facility, individual, organization or agency licensed to provide professional services within the scope of that license or certification. Professional Provider includes, but is not limited to:

1. acupuncturist
2. certified addiction counselors
3. certified registered nurse practitioner
4. chiropractor
5. clinical laboratory
6. clinical licensed social worker (ACSW, LCSW, MSW)
7. clinical psychologist
8. dentist
9. midwife
10. nurse
11. occupational therapist
12. optometrist or optician
13. physical therapist
14. Physician
15. podiatrist
16. respiratory therapist
17. speech therapist
18. Physician's assistant
19. ophthalmologist

All of the above Providers may not be covered by the Plan. Check the Plan Limitations and Exclusions section.

Prosthetics and Orthopedic Braces

Rigid or semi-rigid devices to support or replace all or part of a body function or organ in connection with an Injury or Illness.

Provider Directory

A list of Primary Care Providers and specialty Network Providers that participate in the Network.

Qualified Medical Child Support Order ("QMCSO")

A judgment, decree or order (including approval of a spousal separation agreement) issued by a court of competent jurisdiction or by an administrative process having the force and effect of state law which provides for medical coverage under the Plan with respect to a child of an Employee and which is made pursuant to a state domestic relations law.

Reasonable and Customary

Refer to Usual and Customary.

Referral

When a Primary Care Physician is managing a Covered Person's health needs, the PCP may make Referrals to other providers and specialists for additional care, as needed.

Rehabilitation

The restoration to a condition of health not to exceed a Covered Person's former level of function or useful and constructive activity.

Rehabilitation Facility

A facility licensed to provide comprehensive Rehabilitation services to patients recovering from an Accident or an Illness, and for evaluation and treatment of individuals with physical inabilities with emphasis on education and training. The program must be coordinated and provided by or under the supervision of Physicians who are qualified and experienced in Rehabilitation.

Second Surgical/Medical Opinion

A Medical Opinion provided by a Physician to assure the appropriateness of an elective Surgical Procedure or other course of treatment.

Skilled Nursing Facility

An institution which is:

1. accredited as a Skilled Nursing Facility by The Joint Commission;
2. recognized and eligible for payment under Medicare as a Skilled Nursing Facility; and
3. recognized by the Plan as a Skilled Nursing Facility.

Substance Abuse Treatment

Treatment including, but not limited to, healthcare services and supplies, detoxification and Rehabilitation services provided by a Mental Health Provider in a Hospital or other institution licensed by the appropriate governing regulatory authority to treat alcohol addiction or other chemical dependency. Check the Schedule of Benefits and Plan Limitations and Exclusions section for covered services.

Surgical Procedure

Physician-provided services performed in a Hospital, Ambulatory Surgical Center or Physician's office, including, but not limited to:

1. a cutting operation;
2. treatment of a fracture;
3. reduction of a dislocation;
4. an endoscopic procedure; and
5. any other procedure considered surgery by the American Medical Association.

Urgent Care Center

A facility licensed to provide medical services for unexpected Illnesses or Injuries that require prompt medical attention but are not life- or limb-threatening.

Usual and Customary

The usual charge for medical services and/or supplies which is not higher than the usual charge made or accepted by the provider of the care or supply and does not exceed the usual charge made or accepted by most providers of like services in the same area. The term *area* as it would apply to any particular service, medicine or supply means a zip code or such greater area as is necessary to obtain a representative cross-section of the level of charges as determined by the Plan.

The Plan uses two national studies of charges to chart a range of charges submitted for each geographic area in which the services are provided. Then, when a claim is submitted, the Plan pays all or part of the claim if the amount of the claim is within the usual and customary allowance at the 75th percentile. The Plan, where applicable will negotiate with the provider to determine if that provider will accept less than the 75th percentile. If there are insufficient charges for a service in a geographic area the Plan uses standard relative value methodology to determine the range and usual and customary allowance for the charge submitted.

The Plan will not cover any expenses that are in excess of Usual and Customary expenses. Charges in excess of Usual and Customary expenses are the responsibility of the member unless otherwise indicated and do not apply to the Out-of-Pocket Maximum.

Gray & Son, Inc.
Gray & Son/Maryland Paving Management, Inc.
High Option Plan

MEDICAL PLAN
SCHEDULE OF BENEFITS
Effective 4/1/2021

Maximum Plan Benefit--The Plans annual maximum is unlimited. Benefit-specific maximums apply as indicated on the following chart. A benefit-specific maximum applies as an additional limit with respect to a specific benefit category. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
MEDICAL DEDUCTIBLE, PER PLAN YEAR:		
Per Individual	$400	$1,000
Per Family	$800	$2,000
OUT-OF-POCKET MAXIMUM, PER PLAN YEAR:		
Individual	$2,400	$4,800
Per Family	$4,800	$9,600
Eligible deductible and out-of-pocket expenses apply to both the in-network and out-of-network limits. Copayments do not count toward the deductible. Expenses for penalties for non-certification of hospital admissions, non-covered services treatment and charges in excess of Plan's Allowable Amount do not apply toward the out-of-pocket limit.		
FACILITY CHARGES:		
Inpatient Hospital (Semiprivate) **Precertification Required**	90% of the Plan's Allowable Amount after deductible	70% of the Plan's Allowable Amount after deductible
Nursery Room Charges	90% of the Plan's Allowable Amount after deductible	70% of the Plan's Allowable Amount after the deductible
Emergency Room	$150 copayment, then 100% of Plan's Allowable Amount	$150 copayment, then 100% Plan's Allowable Amount
Urgent Care	$40 copayment, then 100% Plan's Allowable Amount	$40 copayment, then 100% of the Plan's Allowable Amount
Pre-admission Testing	90% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Outpatient Surgery (Hospital or Surgical Center) or Birthing Center	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Outpatient Diagnostic X-Ray and Laboratory	90% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Extended Care Facility (Semiprivate) Maximum is 60 days per Plan year **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Hospice Care (combined inpatient and outpatient with 180 days lifetime maximum) **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Hospice Counseling Family counseling up to $500 per family and Bereavement counseling up to $100 per family within 90 days of patient's death	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Outpatient Therapy Radiation **Prenotification Required** Speech Occupational Respiratory Physical Therapy Cardiac Rehabilitation	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Chemotherapy –**Prenotification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Outpatient Renal Dialysis **Precertification Required – facility must be approved before any expenses are incurred**	90% of the Plan's Allowable Amount after the deductible	Not covered
PRIMARY CARE & WELL CARE CHARGES:		
Office or Telehealth Services – performed and billed by the Primary Care's office including visit, diagnostic x-ray and lab, injections and serum, surgery	$5 copayment then 100% of the Plan's Allowable Amount – **GBMC PCP** $15 copayment then 100% of the Plan's Allowable Amount – **Non-GBMC PCP**	70% of the Plan's Allowable Amount after the deductible
Health Risk Assessment and Biometric Screening when sponsored by Employer	100% of Plan's Allowable Amount	Not applicable
Health Coaching when sponsored by Employer	100% of Plan's Allowable Amount	Not applicable
Inpatient Hospital Visits Primary Care Physician	$15 copayment then 100% of the Plan's Allowable Amount	
Diagnostic Services/X-Ray & Lab Outside Office	90% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Well Adult or Telehealth Services Exams, x-ray/laboratory, immunizations	100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Well Child or Telehealth Services, Through Age 17 Exams, x-ray/laboratory, immunizations	100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Routine GYN Exam and Pap Smear (maximum one per Plan year)	100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Screening Mammogram Under age 40: with physician authorization Age 40 and over: one per Plan year	100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Routine Colonoscopy Age 50 and over, one every five years	100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Women's Preventive Services: - Well women preventive care to obtain recommended preventive services - Human papillomavirus (HPV) testing - Counseling for sexually transmitted infections (STI) - Counseling and screening for human immune-deficiency virus (HIV) - Contraception: FDA approved contraceptive methods, sterilization procedures, education and counseling - Prenatal office visits (not billed with delivery services) - Breastfeeding support and counseling, access to equipment - Screening and counseling for interpersonal and domestic violence	100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
SPECIALIST CHARGES:		
Office or Telehealth Services – performed and billed by the Specialist's Office including visit, diagnostic x-ray and lab, injections and serum, surgery	$30 copayment then 100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Second Surgical Opinion	$30 copayment then 100% of the Plan's Allowable Amount	70% of the Plan's allowable Amount after the deductible
Surgeon – Inpatient or Outpatient	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's allowable Amount after the deductible
Assistant Surgeon - Inpatient or Outpatient	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Anesthesia - Inpatient or Outpatient	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Outpatient Therapy Radiation **Prenotification Required** Speech Occupational Respiratory Physical Therapy Cardiac Rehabilitation	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Chemotherapy –**Prenotification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Outpatient Renal Dialysis **Precertification Required – facility must be approved before any expenses are incurred**	90% of the Plan's Allowable Amount after the deductible	Not covered
Inpatient Hospital Visits and Consultations by Specialist	$30 copayment then 100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Chiropractor (maximum $1,000 per Plan year)	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Acupuncture (maximum $1,000 per Plan year)	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Outpatient Diagnostic X-Ray or Laboratory	90% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Professional Component Inpatient or Outpatient X-Ray or Lab Interpretation	90% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
OTHER FACILITY AND/OR PROFESSIONAL CHARGES:		
Emergency Room Physicians	100% of the Plan's Allowable	100% of the Plan's Allowable
Infusion - Home, Office or Outpatient **Prenotification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Home Health Care Maximum 40 visits per Plan year	$30 copayment then 100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Infertility Treatment (other than office based services but not including AI and IVF and related services – see Plan Limitations and Exclusions)	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Organ Transplant (Mandatory Center of Excellence Network required; travel allowance limited to $5,000 per transplant) **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	Not Applicable
Diabetic and Nutritional Counseling related to diabetes management, (maximum of $300 per Lifetime)	$15 copayment then 100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Dental Procedures for Accidental Injury only within one year from date of accident	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Private Duty Nursing **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Durable Medical Equipment/Prosthetic Devices **Prenotification Required for Devices that cost more than $1,000**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Disposable Medical Devices (Supplies)	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Orthotics One pair covered per Plan year	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Hearing Aids & Batteries for Employees only (maximum paid $500 per Plan year)	100% of the Plan's Allowable Amount	100% of the Plan's Allowable Amount
Wig (if undergoing Chemo or Radiation Therapy)	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Temporomandubular Joint Dysfunction (TMJ) Treatment & Supplies, subject to a $5,000 lifetime maximum)	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Ambulance Service	90% of the Plan's Allowable Amount after the deductible	90% of the Plan's Allowable Amount after the deductible
MENTAL HEALTH BENEFITS:		
Inpatient Hospital (Semiprivate) **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Hospital Visits by Physicians	$30 copayment then 100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Outpatient or Telehealth Services Mental Health Therapy **Prenotification Required for Intensive outpatient services**	$30 copayment then 100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Psychological Testing	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Psychiatric Partial Hospitalization **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
SUBSTANCE ABUSE (DRUG AND ALCOHOL) BENEFITS:		
Detoxification **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible
Detoxification--Inpatient Visits by Physician	$30 copayment the 100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Residential Rehabilitation (Semiprivate) **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Outpatient Alcohol and Substance Abuse Therapy **Prenotification Required for Intensive outpatient services**	$30 do-pay then 100% of the Plan's Allowable Amount	70% of the Plan's Allowable Amount after the deductible
Substance Abuse Partial Hospitalization **Precertification Required**	90% of the Plan's Allowable Amount after the deductible	70% of the Plan's Allowable Amount after the deductible

PLEASE NOTE THAT THIS SCHEDULE IS MERELY A SUMMARY OF SOME FEATURES OF THIS PLAN. ALSO, PLEASE NOTE THAT THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO ANY SERVICES WHICH ARE NOT MEDICALLY NECESSARY, AS DETERMINED BY THE PLAN ADMINISTRATOR. IN ADDITION, THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO SERVICE COSTS WHICH ARE NOT THE PLAN'S ALLOWABLE AMOUNT, AS DETERMINED BY THE PLAN. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

Notes:

1. Benefits for services provided by a participating provider are payable as shown in the Schedule of Benefits. For "in-network" providers please visit the Cigna website at www.Cigna.com; click on "Find a Doctor" and select plan PPO, Choice Fund PPO to locate a participating provider. Verify the provider participates with the PPO (ask the provider) before you receive services to obtain In-Network benefits.

2. The office visit copayment includes diagnostic radiology, pathology, laboratory and other Services such as injections and serum performed in the office and billed by the physician.

3. A Primary Care Physician (PCP) includes a duly licensed doctor who is engaged in the practice of family medicine, general practice, internal medicine, pediatric medicine, and geriatric medicine.

4. If care is rendered at an in-network facility, charges made by a non-network provider (i.e., emergency room physicians, anesthesiologist, radiologists, pathologists and consulting physicians) will be considered as if in-network, subject to the Plan's Allowable Amount.

5. If there is no network provider available within 25 miles of the patient's home, charges will be considered as if "in-network", subject to Plan's Allowable Amount.

Gray & Son, Inc.
Gray & Son/Maryland Paving Management, Inc.
Basic Option Plan

MEDICAL PLAN
SCHEDULE OF BENEFITS
Effective 4/1/2021

Maximum Plan Benefit-- The Plans annual maximum is unlimited. Benefit-specific maximums apply as indicated on the following chart. A benefit-specific maximum applies as an additional limit with respect to a specific benefit category. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
MEDICAL DEDUCTIBLE, PER PLAN YEAR:		
Per Individual	$750	$1,500
Per Family	$1,500	$3,000
OUT-OF-POCKET MAXIMUM, PER PLAN YEAR:		
Individual	$3,250	$7,000
Per Family	$6,500	$14,000
Eligible deductible and out-of-pocket expenses apply to both the in-network and out-of-network limits. Copayments do not count toward the deductible. Expenses for penalties for non-certification of hospital admissions, non-covered services treatment and charges in excess of Plan's Allowable Amount do not apply toward the out-of-pocket limit.		
FACILITY CHARGES:		
Inpatient Hospital (Semiprivate) **Precertification Required**	80% of the Plan's Allowable Amount after deductible	60% of the Plan's Allowable Amount after deductible
Nursery Room Charges	80% of the Plan's Allowable Amount after deductible	60% of the Plan's Allowable Amount after the deductible
Emergency Room	$150 copayment, then 80% of Plan's Allowable Amount	$150 copayment, then 80% Plan's Allowable Amount
Urgent Care	$50 copayment, then 100% Plan's Allowable Amount	$50 copayment, then 100% of the Plan's Allowable Amount
Pre-admission Testing	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Outpatient Surgery (Hospital or Surgical Center) or Birthing Center	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Diagnostic X-Ray and Laboratory	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Extended Care Facility (Semiprivate) Maximum is 60 days per Plan year **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Hospice Care (combined inpatient and outpatient with 180 days lifetime maximum) **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Hospice Counseling: Family counseling up to $500 per family and Bereavement counseling up to $100 per family within 90 days of patient's death	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Therapy Radiation **Prenotification Required** Speech Occupational Respiratory Physical Cardiac Rehabilitation	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Chemotherapy – **Prenotification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Renal Dialysis **Precertification Required – facility must be approved before any expenses are incurred**	80% of the Plan's Allowable Amount after the deductible	Not covered
PRIMARY CARE & WELL CARE CHARGES:		
Office or Telehealth Services – performed and billed by the Primary Care's office including visit, diagnostic x-ray and lab, injections and serum, surgery	$10 copayment then 100% of the Plan's Allowable Amount –**GBMC PCP** $20 copayment then 100% of the Plan's Allowable Amount – **Non-GBMC PCP**	60% of the Plan's Allowable Amount after the deductible
Heath Risk Assessment and Biometric Screening when sponsored by Employer	100% of the Plan's Allowable	Not applicable
Health Coaching when sponsored by Employer	100% of the Plan's Allowable	Not applicable
Inpatient Hospital Visits Primary Care Physician	$20 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Diagnostic Services/X-Ray & Lab Outside Office	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Well Adult or Telehealth Services Exams, x-rays/laboratory, immunizations	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Well Child or Telehealth Services, Through Age 17 Exams, x-ray/laboratory, immunizations	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Routine GYN Exam and Pap Smear Maximum one per Plan year	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Screening Mammogram Under age 40 : with physician authorization Age 40 and over: one per year	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Women's Preventive Services: - Well women preventive care to obtain recommended preventive services - Human papillomavirus (HPV) testing - Counseling for sexually transmitted infections (STI) - Counseling and screening for human immune-deficiency virus (HIV) - Contraception: FDA approved contraceptive methods, sterilization procedures, education and counseling - Prenatal office visits (not billed with delivery services) - Breastfeeding support and counseling, access to equipment - Screening and counseling for interpersonal and domestic violence	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Routine Colonoscopy Age 50 and over, one every five years	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
SPECIALIST CHARGES:		
Office or Telehealth Services – performed and billed by the Specialist's Office including visit, diagnostic s-ray and lab, injections and serum, surgery	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Second Surgical Opinion	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's allowable Amount after the deductible
Surgeon – Inpatient or Outpatient	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's allowable Amount after the deductible
Assistant Surgeon - Inpatient or Outpatient	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Anesthesia - Inpatient or Outpatient	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Therapy Radiation **Prenotification Required** Speech Occupational Respiratory Physical Cardiac Rehabilitation	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Chemotherapy –**Prenotification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Outpatient Renal Dialysis **Precertification Required – facility must be approved before any expenses are incurred**	80% of the Plan's Allowable Amount after the deductible	Not covered
Inpatient Hospital Visits and Consultations by Primary Care Physician	$20 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Inpatient Hospital Visits and Consultations by Specialist	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Chiropractor (maximum $1,000 per Plan year)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Acupuncture (maximum $1,000 per Plan year)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Diagnostic X-Ray or Laboratory	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Professional Component Inpatient or Outpatient X-Ray or Lab Interpretation	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
OTHER FACILITY AND/OR PROFESSIONAL CHARGES:		
Emergency Room Physicians	80% of the Plan's Allowable	80% of the Plan's Allowable
Infusion - Home, Office or Outpatient **Prenotification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Home Health Care Maximum 40 visits per Plan year	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Infertility Treatment (other than office based services but not including AI and IVF and related services – see Plan Limitations and Exclusions)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Organ Transplant (Mandatory Center of Excellence Network required; travel allowance limited to $5,000 per transplant) **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	Not Applicable
Diabetic and Nutritional Counseling related to diabetes management (maximum of $300 per Lifetime)	$20 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Dental Procedures for Accidental Injury only within one year from date of accident	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Private Duty Nursing **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Durable Medical Equipment/Prosthetic Devices **Prenotification Required for Devices that cost more than $1,000**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Disposable Medical Devices (Supplies)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Orthotics One pair covered per Plan year	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Hearing Aids & Batteries for Employees only (maximum paid $500 per Plan year)	100% of the Plan's Allowable Amount	100% of the Plan's Allowable Amount
Wig (if undergoing Chemo or Radiation Therapy)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Temporomandubular Joint Dysfunction (TMJ) Treatment & Supplies, subject to a $5,000 lifetime maximum)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Ambulance Service	80% of the Plan's Allowable Amount after the deductible	80% of the Plan's Allowable Amount after the deductible
MENTAL HEALTH BENEFITS:		
Inpatient Hospital (Semiprivate) **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Hospital Visits by Physicians	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Outpatient or Telehealth Services Mental Health Therapy **Prenotification Required for Intensive outpatient services**	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Psychological Testing	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Psychiatric Partial Hospitalization **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
SUBSTANCE ABUSE (DRUG AND ALCOHOL) BENEFITS:		
Detoxification **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Detoxification--Inpatient Visits by Physician	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Residential Rehabilitation (Semiprivate) **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Alcohol and Substance Abuse Therapy **Prenotification Required for Intensive outpatient services**	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Substance Abuse Partial Hospitalization **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible

PLEASE NOTE THAT THIS SCHEDULE IS MERELY A SUMMARY OF SOME FEATURES OF THIS PLAN. ALSO, PLEASE NOTE THAT THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO ANY SERVICES WHICH ARE NOT MEDICALLY NECESSARY, AS DETERMINED BY THE PLAN ADMINISTRATOR. IN ADDITION, THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO SERVICE COSTS WHICH ARE NOT THE PLAN'S ALLOWABLE AMOUNT, AS DETERMINED BY THE PLAN. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

Notes:

1. Benefits for services provided by a participating provider are payable as shown in the Schedule of Benefits. For "in-network" providers please visit the Cigna website at www.Cigna.com; click on "Find a Doctor" and select plan PPO, Choice Fund PPO to locate a participating provider. Verify the provider participates with the PPO (ask the provider) before you receive services to obtain In-Network benefits.

2. The office visit copayment includes diagnostic radiology, pathology, laboratory and other Services such as injections and serum performed in the office and billed by the physician.

3. A Primary Care Physician (PCP) includes a duly licensed doctor who is engaged in the practice of family medicine, general practice, internal medicine, pediatric medicine, and geriatric medicine.

4. If care is rendered at an in-network facility, charges made by a non-network provider (i.e., emergency room physicians, anesthesiologist, radiologists, pathologists and consulting physicians) will be considered as if in-network, subject to the Plan's Allowable Amount.

6. If there is no network provider available within 25 miles of the patient's home, charges will be considered as if "in-network", subject to Plan's Allowable Amount.

Gray & Son/Maryland Paving Management, Inc.
Low Option Plan
Individual Coverage Only

MEDICAL PLAN
SCHEDULE OF BENEFITS
Effective 4/1/2021

Maximum Plan Benefit-- The Plans annual maximum is unlimited. Benefit-specific maximums apply as indicated on the following chart. A benefit-specific maximum applies as an additional limit with respect to a specific benefit category. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
MEDICAL DEDUCTIBLE, PER PLAN YEAR:		
Per Individual	$2,000	$2,000
Per Family	N/A	N/A
OUT-OF-POCKET MAXIMUM, PER PLAN YEAR:		
Individual	$5,000	$9,000
Per Family	N/A	N/A
Eligible deductible and out-of-pocket expenses apply to both the in-network and out-of-network limits. Copayments do not count toward the deductible. Expenses for penalties for non-certification of hospital admissions, non-covered services treatment and charges in excess of Plan's Allowable Amount do not apply toward the out-of-pocket limit.		
FACILITY CHARGES:		
Inpatient Hospital (Semiprivate) **Precertification Required**	80% of the Plan's Allowable Amount after deductible	60% of the Plan's Allowable Amount after deductible
Nursery Room Charges	80% of the Plan's Allowable Amount after deductible	60% of the Plan's Allowable Amount after the deductible
Emergency Room	$150 copayment, then 80% of Plan's Allowable Amount	$150 copayment, then 80% Plan's Allowable Amount
Urgent Care	$50 copayment, then 100% Plan's Allowable Amount	$50 copayment, then 100% of the Plan's Allowable Amount
Pre-admission Testing	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Outpatient Surgery (Hospital or Surgical Center) or Birthing Center	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Diagnostic X-Ray and Laboratory	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Extended Care Facility (Semiprivate) Maximum is 60 days per plan year **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Hospice Care (combined inpatient and outpatient with 180 days lifetime maximum) **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Hospice Counseling: Family counseling up to $500 per family and Bereavement counseling up to $100 per family within 90 days of patient's death	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Therapy Radiation **Prenotification Required** Speech Occupational Respiratory Physical Cardiac Rehabilitation	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Chemotherapy –**Prenotification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Renal Dialysis **Precertification Required – facility must be approved before any expenses are incurred**	80% of the Plan's Allowable Amount after the deductible	Not covered
PRIMARY CARE & WELL CARE CHARGES:		
Office or Telehealth Services – performed and billed by the Primary Care's office including visit, diagnostic x-ray and lab, injections and serum, surgery	$10 copayment then 100% of the Plan's Allowable Amount **–GBMC PCP** $20 copayment then 100% of the Plan's Allowable Amount – **Non-GBMC PCP**	60% of the Plan's Allowable Amount after the deductible
Health Reimbursement and biometric screening when sponsored by Employer	100% of Plan's Allowable Amount	Not applicable
Health Coaching when sponsored by Employer	100% of Plan's Allowable Amount	Not applicable
Inpatient Hospital Visits Primary Care Physician	$20 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Diagnostic Services/X-Ray & Lab Outside Office	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Well Adult or Telehealth Services Exams, x-ray/laboratory, immunizations	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Well Child or Telehealth Services, Through Age 17 Exams, x-ray/laboratory, immunizations	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Routine GYN Exam and Pap Smear Maximum one per plan year	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Screening Mammogram Under age 40 : with physician authorization Age 40 and over: one per year	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Women's Preventive Services: - Well women preventive care to obtain recommended preventive services - Human papillomavirus (HPV) testing - Counseling for sexually transmitted infections (STI) - Counseling and screening for human immune-deficiency virus (HIV) - Contraception: FDA approved contraceptive methods, sterilization procedures, education and counseling - Prenatal office visits (not billed with delivery services) - Breastfeeding support and counseling, access to equipment - Screening and counseling for interpersonal and domestic violence	100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Routine colonoscopy Age 50 and over, one every five years	100% of the Plan's Allowable Amount	60% of the Plan's Allowable amount after the deductible
SPECIALIST CHARGES:		
Office or Telehealth Services – performed and billed by the Specialist's Office including visit, diagnostic x-ray and lab, injections and serum, surgery	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Second Surgical Opinion	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's allowable Amount after the deductible
Surgeon – Inpatient or Outpatient	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's allowable Amount after the deductible
Assistant Surgeon - Inpatient or Outpatient	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Anesthesia - Inpatient or Outpatient	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Therapy Radiation **Prenotification Required** Speech Occupational Respiratory Physical Cardiac Rehabilitation	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Chemotherapy –**Prenotification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Renal Dialysis **Precertification Required – facility must be approved before any expenses are incurred**	80% of the Plan's Allowable Amount after the deductible	Not covered
Inpatient Hospital Visits and Consultations by Primary Care Physician	$20 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Inpatient Hospital Visits and Consultations by Specialist	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Chiropractor (maximum $1,000 per Plan year)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Acupuncture (maximum $1,000 per Plan year)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Diagnostic X-Ray or Laboratory	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Professional Component Inpatient or Outpatient X-Ray or Lab Interpretation	80% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
OTHER FACILITY AND/OR PROFESSIONAL CHARGES:		
Emergency Room Physicians	80% of the Plan's Allowable	80% of the Plan's Allowable
Infusion - Home, Office or Outpatient **Prenotification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Home Health Care Maximum 40 visits per Plan year	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Infertility Treatment (other than office based services but not including AI or IVF or related services – see Plan Limitations and Exclusions)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Organ Transplant (Mandatory Center of Excellence Network required; travel allowance limited to $5,000 per transplant) **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	Not Applicable
Diabetic and Nutritional Counseling related to diabetes management, (maximum of $300 per Lifetime)	$20 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Dental Procedures for Accidental Injury only within one year from date of accident	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Private Duty Nursing **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Durable Medical Equipment/Prosthetic Devices **Prenotification Required for Devices that cost more than $1,000**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Disposable Medical Devices (Supplies)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Orthotics One pair covered per plan year	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Hearing Aids & Batteries for Employees only (maximum paid $500 per Plan year)	100% of the Plan's Allowable Amount	100% of the Plan's Allowable Amount
Wig (if undergoing Chemo or Radiation Therapy)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Temporomandubular Joint Dysfunction (TMJ) Treatment & Supplies, subject to a $5,000 lifetime maximum)	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Ambulance Service	80% of the Plan's Allowable Amount after the deductible	80% of the Plan's Allowable Amount after the deductible
MENTAL HEALTH BENEFITS:		
Inpatient Hospital (Semiprivate) **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Hospital Visits by Physicians	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Outpatient or Telehealth Services Mental Health Therapy **Prenotification Required for Intensive outpatient services**	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Psychological Testing	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Psychiatric Partial Hospitalization **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
SUBSTANCE ABUSE (DRUG AND ALCOHOL) BENEFITS:		
Detoxification **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible

TYPE OF EXPENSE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Detoxification--Inpatient Visits by Physician	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Residential Rehabilitation (Semiprivate) **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible
Outpatient Alcohol and Substance Abuse Therapy **Prenotification Required for Intensive outpatient services**	$40 copayment then 100% of the Plan's Allowable Amount	60% of the Plan's Allowable Amount after the deductible
Substance Abuse Partial Hospitalization **Precertification Required**	80% of the Plan's Allowable Amount after the deductible	60% of the Plan's Allowable Amount after the deductible

PLEASE NOTE THAT THIS SCHEDULE IS MERELY A SUMMARY OF SOME FEATURES OF THIS PLAN. ALSO, PLEASE NOTE THAT THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO ANY SERVICES WHICH ARE NOT MEDICALLY NECESSARY, AS DETERMINED BY THE PLAN ADMINISTRATOR. IN ADDITION, THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO SERVICE COSTS WHICH ARE NOT THE PLAN'S ALLOWABLE AMOUNT, AS DETERMINED BY THE PLAN. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

Notes:

1. Benefits for services provided by a participating provider are payable as shown in the Schedule of Benefits. For "in-network" providers please visit the Cigna website at www.Cigna.com;click on "Find a Doctor" and select plan PPO, Choice Fund PPO to locate a participating provider. Verify the provider participates with the PPO (ask the provider) before you receive services to obtain In-Network benefits.

2. The office visit copayment includes diagnostic radiology, pathology, laboratory and other Services such as injections and serum performed in the office and billed by the physician.

3. A Primary Care Physician (PCP) includes a duly licensed doctor who is engaged in the practice of family medicine, general practice, internal medicine, pediatric medicine, and geriatric medicine.

4. If care is rendered at an in-network facility, charges made by a non-network provider (i.e., emergency room physicians, anesthesiologist, radiologists, pathologists and consulting physicians) will be considered as if in-network, subject to the Plan's Allowable Amount.

5. If there is no network provider available within 25 miles of the patient's home, charges will be considered as if "in-network", subject to Plan's Allowable Amount.

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MEDICAL PLAN

The Health Care Plan ("Plan") is a valuable part of your benefits program that encourages you to seek a healthy lifestyle and provides comprehensive coverage in the event that you become ill or diagnosed with a serious problem. The Plan helps pay the Medically Necessary costs of eligible medical services, supplies, and treatment of a sickness or Injury, and certain wellness benefits.

Allegeant is the claims and service administrator for the Plan.

The highest level of benefits will apply when you select an In-Network provider. The lower level of benefits will apply when you select an Out-of-Network provider.

If you need help finding a network provider in your area you can obtain the name of one from the following sources:

- The Cigna Network www.Cigna.com; click Find a Provider and select plan PPO, Choice Fund PPO.

If you use an out-of-network medical provider, you will be responsible for the higher out-of-network deductible, copays and coinsurance. Non-participating providers have no contractual status with CIGNA and may not be reimbursed directly by Allegeant. You may be responsible for paying your provider in full, and then you will be reimbursed directly by Allegeant based on the "usual, customary and reasonable charges" (UCR) for the services rendered. Allegeant utilizes Eplan to negotiate out-of-network claims when UCR is not appropriate.

If there is no network provider available within 25 miles of the patient's home, charges will be considered as if in-network, subject to the Plan's allowable amount limitations. In addition, if care is rendered at an in-network facility charges made by a non-network provider (i.e., emergency room physicians, anesthesiologist, radiologists, pathologists and consulting physicians) will be considered as if in-network, subject to the Plan's allowable amount limitations. If you are taken by ambulance to a non-network facility, the facility and any non-network providers that treated you will be paid as if in-network subject to the Plan's allowable amount limitations.

Health Plan

The Plan offers three Medical Plans for eligible employees and their eligible dependents. A complete description of the benefits is provided in the Medical Plan Schedule of Benefits in this Summary Plan description.

Other important information concerning the applicability of certain provisions in the plan:

Plan Provisions:

Deductible – The Deductible is a specified dollar amount that must be paid for Covered Services each Plan Year, before the Plan will provide benefits. In-Network and Out-of-Network deductibles will offset each other.

Individual Coverage Deductible **–** Each Participant's annual deductible is shown in the applicable Schedule of Benefits. This deductible must be met once each Plan year and applies to Covered Services indicated in the Schedule of Benefits.

Family Coverage Deductible **-** The Family Coverage Deductible is shown in the Schedule of Benefits. When the deductible amounts accumulated by the members of a family reach the total shown in the Schedule of Benefits during a Plan Year, no further deductibles will apply to any family members for the rest of that Plan Year. No individual member under the family coverage deductible will be required to satisfy more than the individual coverage deductible maximum.

Out-of-Pocket Limit – The Out-of-Pocket Limit is the amount you are responsible for paying for a Covered Service. This amount includes the deductible, applicable copayments (not including prescription copayments) and coinsurance. Penalties for non-certified hospital admissions, non-covered services, and charges in excess of Usual and Customary allowance do not apply toward the Out-of-Pocket Limit. In-Network and Out-of-Network Out-of-Pocket limits will offset each other.

Individual Coverage Out-of-Pocket Limit – After a Participant with Individual Coverage meets the amount shown in the Schedule of Benefits, the Plan will pay 100% of the Plan's allowable amount for all Covered Services for the remainder of that Plan Year, except as noted above and in the Schedule of Benefits.

Family Coverage Out-of-Pocket Limit - . After the family's total Out-of-Pocket expenses incurred by the members of the family reach the maximum amount shown in the Schedule of Benefits, the Plan will pay 100% of the Plan's allowable amount for all Covered Services for all family members for the remainder of that Plan Year, except as noted above and in the Schedule of Benefits. No individual member under the family coverage out-of-pocket limit will be required to satisfy more than the individual coverage out-of-pocket limit.

Other Important Information:

Copayment - The dollar amount (shown in the Schedule of Benefits) a Participant is required to pay for a covered service. A copayment is expressed as a flat dollar amount and does not apply toward the Deductible.

Maximum Benefits - Benefit specific maximums apply as indicated on the Schedule of Benefits and are offset by In-Network and Out-of-Network services.

Health Plan Review Program
A PATIENT ADVOCATE PROGRAM

One of the features of the Plan is a Patient Advocate Program. This program can help Covered Persons participating in the program learn more about how to use their health care benefits and make informed decisions about their medical treatment.

The Plan encourages you and your Dependents to seek the best and most appropriate health care services. Because most of us are unfamiliar with the health care environment, we may not feel comfortable enough to make an informed decision about our medical treatment or know how to arrange for a prescribed treatment plan or know the kinds of questions to ask. The Patient Advocate Program acts as a patient resource to help answer your questions and help you through what is sometimes referred to as the "health care maze."

The program also works with your Primary Care Physician in certain instances to keep them informed. They can then provide you with more appropriate care decisions for your particular situation.

You begin to become involved with the program if you:

- are admitted to the Hospital;
- become pregnant;
- become aware that an organ or transplant may be needed;
- need specific services as identified below;
- are diagnosed with a serious illness or condition; or
- need extensive outpatient services

Outpatient care includes all services other than inpatient Hospital, such as outpatient Hospital, laboratory, X-ray, physical therapy, and doctors' visits.

Once you become a participant in the Patient Advocate Program, a nurse care manager works along with you and your Primary Care Physician as an advocate. The program does not interfere with your patient/doctor relationship in any way. By working with the nurse care manager, you can strive to receive the most appropriate care while effectively using the health benefits available to you through our Medical Plan.

Feel free to use your nurse care manager as a resource to help to answer your questions--such as what particular types of treatment will be covered by the Plan. The nurse can help arrange for services prescribed by your Physician. And, most importantly, the nurse will keep in touch with you to ask if your treatment plan is working to your satisfaction.

How the Program Works

The Patient Advocate Program is easy to use--just remember these few simple guidelines:

- Call prior to any planned inpatient Hospital stay or within 48 hours after an emergency admission.

- Call during the first three months (trimester) of a pregnancy, or as soon as the pregnancy is confirmed.

- Call as soon as you become aware that an organ or tissue transplant may be needed. The Plan provides you access to a "center of excellence" program for treatment-intensive and costly organ and tissue transplants. This transplant management program is mandatory and involves contracting with medical centers that have demonstrated clinical excellence in this specific field. Through accessing these "centers" you can enhance the potential for positive clinical outcomes while reducing costs for both yourself and the Plan.

- Call to precertify (receive approval) for certain other benefits listed in the Schedule of Benefits. Benefits subject to precertification include, but not limited to, inpatient hospitalization, partial hospitalization, dialysis, extended care facility, hospice care, private duty nursing and residential rehabilitation for substance abuse.

- Call to prenotify if your physician recommends you receive the following services:

    - Organ Biopsy
    - Radiation Therapy
    - Chemotherapy
    - Intravenous Infusion Therapy
    - Durable medical equipment that costs $1,000 or more
    - Intensive Outpatient Mental Health or Substance Abuse treatment

Call Allegeant at 1-800-793-9403 to precertify or prenotify any of the services above.

Extraordinary circumstances for complex diagnosis and illnesses:

When you or a dependent are diagnosed with a serious illness or a catastrophic condition, such as a spinal cord injury, cancer, or a premature birth occurs, a person may require long-term, perhaps lifetime care. A Nurse Care Manager can help you to understand and use your benefits more effectively, arrange for treatment ordered by your Physician, answer questions, and refer you to Network participating Physicians. Contact the Nurse Care Manager as soon as you are aware of a serious condition so the case manager can begin assisting you.

In this situation a Nurse Care Manager is assigned to monitor the patient and explore, discuss and recommend coordinated and/or alternate types of appropriate Medically Necessary Care. The Nurse Care Manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. The plan of care may include some or all of the following:

- personal support to the patient;

- contacting the family to offer assistance and support;

- monitoring Hospital, Skilled Nursing Facility, Home Health Care and Hospice Care;

- determining alternative care options; and

- assisting in obtaining any necessary equipment and services.

The Nurse Care Manager will coordinate and implement the program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

In appropriate special cases, the Nurse Care Manager can recommend that the Plan consider offering benefits that may not be ordinarily covered by the Plan. The Claim Processor will obtain in a confidential manner the necessary approval from the Plan Administrator and, if approved, have the Plan reimburse for allowable claims that are medically necessary expenses as stated in the treatment plan, even if the expense normally would not be paid by the Plan.

Nurse Care Managers are provided by Conifer Medical Management Services. Conifer Medical Management Services toll free number is 1-866-397-1698.

Plan Penalties for Non-Compliance

Because the Patient Advocate Program is such an important part of the Medical Plan, all Covered Persons must follow the guidelines in order to receive full Plan benefits. If the Claims Administrator is not contacted prior to a planned Hospital admission, or within 48 hours of an emergency admission, Plan benefits will be reduced by $1,000 and the Penalty amount you pay will not count toward your Out-Of-Pocket Maximum (OOP) limits.

Please be sure to call in order to receive the maximum benefit allowed under the Plan. All you need to do is make a phone call in order to avoid paying expenses for medical care that will not be covered by the Plan if notification guidelines are not followed.

COVERED MEDICAL SERVICES

The Plan's medical benefit level depends on the type of service and on whether treatment is received from a Network or Out-Of-Network Provider. Refer to the Schedule of Benefits section for detail on specific benefit levels. Specific services not described in the Schedule of Benefits are not covered by the Plan.

Plan benefits also may be subject to limitations and exclusions contained in this Summary.

A. Inpatient Hospital.

IMPORTANT: All Hospital confinements must be Pre-Certified before the individual is admitted in order to be eligible for full Plan coverage. Please refer to the Health Care Plan Review Program for more information.

Inpatient Hospital expenses (including inpatient Rehabilitation) are eligible for Inpatient Hospital coverage under the Plan, as specified in the Schedule of Benefits.

Federal law prohibits the Plan from limiting Hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections. In addition, on such date, Federal law prohibits the Plan from requiring that any provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods, and from imposing a penalty on an individual for failing to obtain preauthorizations for Hospital stays of such duration.

B. Outpatient Hospital.

Outpatient Hospital expenses are eligible for Outpatient Hospital coverage under the Plan, as specified in the Schedule of Benefits.

C. Physician Charges.

Physician charges incurred at a facility are eligible for coverage under the Plan, as specified in the Schedule of Benefits. Second surgical opinions received from a Physician prior to an elective Surgical Procedure are covered, although second surgical opinions are not mandatory.

Note that, although surgeon's fees are eligible for Plan coverage, as specified in the Schedule of Benefits, if two or more Surgical Procedures are performed in the same operative field and are considered incidental or related, the Plan will consider 100% of the Plan’s Allowable Amount for the most expensive procedure only. If Surgical Procedures are performed at the same time in different operative fields, benefits will be paid as follows: 100% of the Plan’s Allowable Amount for the highest billed procedure and 50% of the Plan’s Allowable Amount for all remaining billed procedures.

Assistant surgeon's fees are eligible for Plan coverage, as specified in the Schedule of Benefits, up to 20% of the Plan’s Allowable Amount for the primary surgeon.

Chiropractic treatment and podiatrist treatment (except routine foot care or routine chiropractic care) are eligible for coverage under the Plan, as specified in the Schedule of Benefits.

D. Specialized Care.

Outpatient Dialysis treatment

Important: All treatment for renal dialysis must be Pre-Certified before in order to be eligible for Plan Coverage. Please refer to the Health Care Plan Review Program for more information.

Generally a program of renal dialysis can be performed in the outpatient department of a hospital, in a dialysis facility or center, or in the home. In order to receive benefits for any medically necessary treatment for renal dialysis the facility must be approved for full Plan coverage.

Extended Care Facility

IMPORTANT: All Extended Care Facility confinements must be Pre-Certified before the individual is admitted in order to be eligible for full Plan coverage. Please refer to the Health Care Plan Review Program for more information.

A Physician may recommend continuing care in an Extended Care Facility, which can offer quality care at rates generally below those charged by Hospitals.

The Plan covers all eligible charges. However, to receive benefits, the patient must:

1. enter the Extended Care Facility within 7 days following a stay of at least 3 days in a regular Hospital;

2. be confined for the same or related condition which caused the Hospital confinement;

3. be under the continuous care of a doctor; and

4. require 24-hour nursing care which is recommended by a doctor.

Confinements separated by less than 7 days are considered one confinement.

For the purpose of Plan coverage, an Extended Care Facility may not be used mainly as a place for rest, the aged, custodial treatment, or the treatment of mental Illness, alcoholism, drug abuse, or pulmonary tuberculosis.

Eligible expenses include charges for semiprivate room and board, X-rays and laboratory services, specialized treatment rooms, and drugs and other medication. Personal items are not covered.

Hospice Care

Note: All Hospice Care must be Pre-Certified in order to be eligible for Plan coverage. Please refer to the Health Care Plan Review Program for more information.

The Plan pays eligible inpatient and outpatient Hospice Care expenses. A Hospice is a special program of care for a terminally ill Covered Person diagnosed to have six months or less to live. The Covered Person is cared for by a team of professionals and volunteer workers, which generally includes a doctor and a registered nurse, and may include a dietary counselor, home health aide, medical social worker, or others.

The goals of the Hospice are to provide an alert and pain-free existence for the Covered Person and to keep the family actively involved in the care.

A special reserve of 45 Hospice days is available if the patient survives the 180 days lifetime expectancy. The special reserve is available for inpatient or outpatient hospice care; however, if used for inpatient hospice care, the patient's condition must be such that he or she would have to be admitted to an acute care facility if hospice care were not available.

Home Health Care

While you or a Dependent are under a doctor's care, the Plan provides benefits for charges made by a licensed Home Health Care agency. The Physician must submit a written treatment plan approximately every three months indicating the patient would otherwise need to be confined in a Hospital or Extended Care Facility if home care were not provided.

Any single visit up to 4 hours by a member of a Home Health Care agency provider will equal one (1) Home Health Care Visit.

Services and supplies must be provided by a licensed health care organization and may not be performed by a relative or anyone living in your household.

Non-covered home Health Care Services include:

1. domestic or housekeeping service
2. meals-on-wheels or other similar food arrangements
3. home care provided in a nursing home or Skilled Nursing Facility
4. home care for mental and nervous conditions
5. custodial care

Organ Transplant and mandatory Center of Excellence Network

The Plan will pay for covered expenses related to services performed for human-to-human organ or tissue transplants incurred by you or your dependent as a recipient. Any replacement of tissue or organs that is determined to be non-investigational and non-experimental and is commonly and customarily recognized by the medical profession as appropriate treatment of a condition will be covered by the Plan as any other Illness subject to medical necessity and other Plan limitations as described herein.

Human-to-human organ or tissue transplants include autologous and allogenic bone marrow transplants, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.

When the recipient is a member of the Plan, Organ transplant benefits are available for both the recipient and the donor. When the donor has medical coverage, the donor's plan will pay first and benefits under this Plan will be reduced by those payable under the donor's plan. When only the donor is a member of the Plan, Organ transplant benefits are available for the donor only, and then only if the recipient has no benefits available for the donor.

The Plan provides you access to a "Center of Excellence" program for organ and tissue transplants. **Participation in the Center of Excellence program is mandatory for in-network benefits. There are no out-of-network benefits for Organ transplants**. Reimbursement for travel and lodging outside the immediate home area and during the transplant, as determined by the Plan Administrator, will be covered to a maximum of $5,000 for the member and one companion. All planned Organ Transplant must be pre-certified and approved. **Please refer to the Health Care Plan Review Program for more information.**

Covered expenses include:

- Charges incurred for selective testing of potential donors for an organ registry but not for screening of the general population
- Clinical evaluation at the Organ Transplant hospital just prior to the scheduled Organ Transplant
- Organ or tissue procurement within the United States consisting of removing, preserving and transporting the donated part
- Transplant services furnished by the facility provider and treatment and surgery furnished by a professional provider
- Travel allowance for the covered recipient and donor as follows: if the transplant provider is located 50 miles or more from the recipient's home.
- Transportation using a motor vehicle will be paid in accordance with the current IRS allowance per mile for medical travel
- Hotel accommodations up to $75 per day at hotels should you be released to an outpatient facility for medically necessary post-surgical care from the Transplant Program Provider

- Hotel accommodations up to $75 per day at hotels for your travel companion to remain in the immediate area during all or a portion of the duration of your treatment plan
- Daily meals and other reasonable and necessary services or supplies for you and your travel companion up to an allowance of $75 per person per day

Refer to the Schedule of benefits for the maximum benefits payable by the Plan.

Transplant Program Provider is the Physician performing the transplant and/or Hospital in which the transplant is performed.

Under the Organ Transplant benefit, the following services are not provided:

- Travel, lodging and other charges for your travel companion other than to accompany you to and from the Transplant Program Provider
- Charges in connection with the Travel Allowance that are not related to your travel to and from the Transplant Program Provider except for charges for your treatment while at the Transplant Program Provider
- Charges for the repair or maintenance of a motor vehicle
- Personal expenses incurred for the maintenance of you and your travel companion's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges
- Reimbursement of any wages lost by you or your travel companion
- The services and medical expenses incurred by a donor (except as specified above) as a result of such transplant procedure

E. Other Eligible Medical Services.

In addition to the coverages noted above, the Plan provides coverage subject to medical necessary and Plan limitations and exclusions, as specified in the Schedule of Benefits, for the following:

1. oxygen and its administration

2. outpatient chemotherapy and radiotherapy

3. outpatient renal dialysis

4. approved Durable Medical Equipment (DME), up to the purchase price of the equipment rented, including replacements of original equipment if such equipment breaks and cannot be repaired. The Plan pays for standard DME which provides the basic therapeutic or functional purpose necessary for the Member's condition but does not pay for deluxe DME which has features not necessitated by the patient's medical condition. Benefits for the initial services or supplies for eyeglasses or contact lenses, or hearing aids/fitting thereof, may be provided when such services or supplies are required as a result of an accidental bodily injury occurring while the patient is covered under the medical plan

5. approved prosthetic devices, including replacements of original prosthetic devices if such devices break and cannot be repaired

6. casts, splints, jobst garments, orthotics (see Schedule of Benefits for orthotic limitation)

7. diabetic education and nutritional counseling related to diabetes management (see Schedule of Benefits for education and counseling limitation), diabetic equipment and supplies, except supplies covered by the Prescription Drug Plan

8. outpatient occupational or speech therapy if medically necessary, prescribed by a Physician, and rendered by a qualified provider, except as specifically excluded below in the Plan Limitations and Exclusions section

9. outpatient physical therapy

10. cosmetic surgery for the repair of an Injury, reconstructive surgery from a sickness or Illness, and the correction of a congenital defect that results in a functional defect of the insured's child

11. voluntary sterilization

12. oral surgery necessary to treat cleft lip and palate, frenectomy, dislocation or fracture of the jaw or facial bones, or excision of a tumor of the jaw or mouth

13. impacted wisdom teeth (if you have both Medical and Dental coverage provided by, treatment of soft and bony tooth impactions are considered under the Medical Benefits. If you only have Dental coverage the tooth impactions will be covered under the Dental Benefits.

14. accidental Injury to natural teeth or jaw (if treatment is rendered within one year of Accident), except for Injuries caused by biting or chewing by the injured individual

15. treatment of temporomandibular joint syndrome (TMJ) including diagnostic and testing, appliances and surgical procedures for a medical diagnosis (see Schedule of Benefits for Plan limitation)

16. blood plasma, if not replaced

17. professional nursing services by a registered graduate nurse (R.N.), Licensed Practical Nurse (L.P.N.) as long as the individual is not a relative or living in the home of the patient (Nursing care must be Pre-Certified. Please refer to the Managed Care information.)

18. Norplant, IUDs or diaphragms

19. ground or air ambulance service to and from the nearest Hospital where necessary care and treatment can be provided

20. maternity for Dependent children

21. travel, transportation and donor costs associated with non-experimental organ transplants

22. allergy testing

23. infertility treatment, but not to include AI and IVF and related services (see specific exclusions in the Plan Limitations and Exclusions Section)

24. hearing examinations to include testing. Hearing Aids & Batteries for Employees only (maximum paid $500 per Plan year)

25. acupuncture

26. wigs or hair pieces due to hair loss related to chemo or radiation therapy (see Schedule of Benefits for limitations)

27. Clinical Trial – Coverage relating to Clinical Trials as required under the Patient Protection and Affordable Care Act (ACA):

    The Medical Plan is prohibited under federal law from:

    1. Denying the individual participation in an approved clinical trial.
    2. Denying or limiting, or imposing additional conditions on, the coverage of routine patient costs or services furnished in conjunction with participation in the approved clinical trial
    3. Discriminating against the individual on the basis of the individual's participation in the approved clinical trial.

    Qualified individual. A qualified individual is defined under the plan as an individual who is enrolled or participating in the health plan and who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. To be a qualified individual, there is an additional requirement that a determination be made that the individual's participation in the approved clinical trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information by the individual.

    Approved clinical trial. The term "approved clinical trial" is defined as a phase I, phase II, phase Ill, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or life threatening disease or condition and is one of the following:

    1. A federally funded or approved trial.
    2. A clinical trial conducted under an FDA investigational new drug application.

3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Covered Services - Routine patient costs. With some important exceptions, routine patient costs generally include all items and services consistent with the coverage provided under the plan for a qualified individual (for treatment of cancer or another life-threatening disease or condition) who is not enrolled in a clinical trial. However, costs associated with the following are excluded and the Medical Plan is not required under federal law to pay for the following:

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

28. Telehealth services with Primary Care, Specialist or Mental Health Provider

29. other Medically Necessary services and supplies as specifically provided in the Schedule of Benefits

F. Well Care.

The Medical Plan includes benefits for adult and children preventive services as outlined by the Patient Protection Affordable Care Act (PPACA). These benefits can help you and your Dependents remain healthy and productive. Under the PPACA rules, preventive health services recommended by the U.S. Preventive Services Task Force (USPSTF) will generally be required to be provided without cost sharing when delivered by an in-network provider. Recommendations of the USPSTF for Grade A and B preventive health services can be found in a chart on the USPSTF web site (www.ahrq.gov).

Generally, the preventive health services are listed in three broad categories:

- Covered Preventive Services for Adults
- Covered Preventive Services for Women, including Pregnant Women
- Covered Preventive Services for Children

These benefits can help you and your Dependents remain healthy and productive. It is important for you to understand that when you see your primary care physician (family doctor) for your annual visit that you discuss with him or her that you are there for your annual "wellness exam". The doctor codes your encounter based on the general purpose of your visit. If it is a wellness visit, then your doctor will code the encounter as a "wellness" visit and the health plan will pay any of the preventive health services at 100%.

On the other hand, you may see your doctor for a particular problem and even though some services provided may be similar to "preventive health services" the encounter is "diagnostic" in nature and the office visit and other services will be subject to copayments, coinsurance and deductibles as listed in the Schedule of Benefits.

Well care services listed in the Schedule of benefits include but are not limited to:

- periodic adult well visit exams
- prostate screenings
- routine gynecological visits
- mammography screenings
- routine PAP smears
- well child care
- immunizations and inoculations
- fecal occult screenings
- routine colonoscopy
- routine x-ray and lab

The Plan also provides expanded prevention coverage for Women without cost sharing under the Patient Protection and Affordable Care Act (ACA) guidelines. These services include:

a. Well-women preventive care visit annually (or as needed) for adult women to obtain the recommended preventive services that are age and developmentally appropriate. Screening for gestational diabetes
b. Human papillomavirus (HPV) testing: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
c. Counseling for sexually transmitted infections (STI) for all sexually active women
d. Counseling and screening for human immune-deficiency virus (HIV) for all sexually active women
e. Contraception: FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
f. Breastfeeding support and counseling from trained providers, as well as access to breastfeeding equipment, for pregnant and nursing women
g. Screening and counseling for interpersonal and domestic violence for all women

Employer sponsored biometric screenings and health coaching are also made available. The availability of these services is communicated separately by the Employer.

G. Mental Health Treatment.

IMPORTANT: All inpatient mental health treatment must be Pre-Certified. Please refer to the Health Care Plan Review Program for more information.

Inpatient Treatment.

Certain in-hospital mental health expenses are eligible for coverage. Eligible expenses include certain charges for semiprivate room and board, and all Medically Necessary medical services and supplies. Certain inpatient doctor visits are also eligible.

The care must meet all utilization review requirements.

Outpatient Treatment.

Certain outpatient expenses are covered. Eligible expenses include those of a Physician, psychiatrist, psychologist, or licensed certified social worker. See Schedule of Benefits for Network and non-Network benefits.

H. Substance Abuse Treatment.

IMPORTANT: All inpatient substance abuse services must be pre-Certified. Please refer to the Health Care Plan Review Program for more information.

When a doctor recommends that you or a Dependent need treatment for alcoholism or drug abuse, our Plan provides benefits for the following services:

1. Emergency care and detoxification services in a general Hospital or licensed non-Hospital detoxification facility.

2. Residential Rehabilitation services in a licensed and certified facility. Services include:
   --semiprivate room and board charges
   --medical and nursing services
   --individual and group therapy
   --individual, group, and family counseling
   --drugs, biologicals, and solutions dispensed by the facility
   --psychological testing

3. Outpatient Rehabilitation services in a licensed Outpatient Alcoholism Treatment Facility or by a Professional Provider who specializes in substance abuse treatment.

4. The care must meet all utilization review requirements.

I. Required Coverage for Reconstructive Surgery Following Mastectomies

IMPORTANT: All inpatient services for reconstructive surgery following a mastectomy must be Pre-Certified before the individual is admitted in order to be eligible for full Plan coverage. Please refer to the Health Care Plan Review Program for more information.

The following benefits are provided to all Plan participants who elect breast reconstruction in connection with a mastectomy:

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

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

(3) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The benefits will be provided in a manner determined in consultation with the attending Physician and the patient.

Deductibles and Coinsurance apply. Please refer to the Schedule of Benefits for detailed information regarding the level of coverage for specific services, e.g. facility charges, prosthetic devices.

The Plan will not deny eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the Plan, solely to avoid providing the above benefits. Further, the Plan will not penalize or otherwise reduce or limit the reimbursement of an attending Professional Provider or provide incentives (monetary or otherwise) to an attending provider, to induce the Professional Provider to provide care to an individual participant or beneficiary in a manner which is inconsistent with the Women's Health and Cancer Rights Act of 1998.

J. Plan Limitations and Exclusions.

The Medical Plan **does not** cover charges for the following:

1. for custodial care, residential care or rest cures

2. services and supplies not recommended and approved by a Physician or determined not to be medically appropriate or necessary

3. for a private room beyond the amount normally paid for a semiprivate room

4. cosmetic surgery unless resulting from an Accidental Injury or sickness or because of a congenital malformation of a child

5. treatment received in a government Hospital or at government expense for a service-connected disability

6. reversal of sterilization

7. routine foot care (such as corns, calluses, or toenails) except diabetic foot care

8. medical services for dietary control (unless surgical treatment due to morbid obesity)

9. glasses, contact lenses, eye refractions, or the examinations for their fitting or prescription, except when necessary after cataract surgery. Refer to the Vision Plan document for non-medical vision benefits

10. correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy, Laser In-Situ Keratomileusis (LASIK) and all related services

11. education, research, or training programs including vision therapy

12. experimental or investigational treatment, including transplants using non-human organs

13. claims filed more than one year after the expenses were incurred

14. expenses incurred before or after the individual was covered by the Plan

15. charges for personal hygiene and convenience items including, but not limited to air conditioners, humidifiers, physical fitness equipment, electric heating units, orthopedic mattresses, blood pressure measuring instruments, scales, first aid equipment, elastic bandages or stockings (unless recommended by a Physician), and in-Hospital television, telephone or extra meals

16. charges for missed appointments, or for completion of claim forms

17. charges in connection with (1) an Injury arising out of, or in the course of any employment for wage or profit, or (2) a disease covered with respect to such employment, by any Workers' Compensation law, occupational disease law, or similar legislation

18. treatment of any Injury sustained or disease resulting from war, act of war, riot, rebellion, civil disobedience, during the commission of a crime or from military service in any country

19. intentionally self-inflicted injury or sickness, unless the injury or sickness was inflicted because of a physical or mental condition.

20. charges reimbursable by no-fault auto insurance, or any other federal or state mandated law

21. charges which you or a Dependent are not legally required to pay

22. charges that would not be made if no coverage existed

23. charges by a provider who is a member of your immediate family (spouse, child, brother, sister, or parent, grandparent)

24. charges otherwise payable as described under the Coordination of Benefits provision

25. dental charges including services to remove impacted wisdom teeth (unless otherwise noted in schedule of benefits)

26. maternity for persons other than the covered employee and his or her eligible Dependents

27. hair loss treatment including wigs and artificial hair pieces unless hair loss is due to chemo or radiation therapy (see Schedule of Benefits for limitations)

28. charges for transsexual surgery

29. marital or family counseling

30. complications arising from a non-covered Surgical Procedure

31. oral contraceptives (see Prescription Drug Plan)

32. for charges made which are in excess of Usual and Customary charges

33. for travel, whether or not recommended by a Physician, except as specifically provided in this Plan

34. for expenses in connection with an Injury arising out of or relating to an Accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any Injury arising out of an Accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a Covered Person who is a non-driver when involved in an uninsured motor vehicle.

    For purpose of this exclusion, a non-driver is defined as a Covered Person who does not have the obligation to obtain automobile insurance because he/she does not have a driver's license or because he/she is not responsible for a motor vehicle

35. for Injury sustained while an active participant in a professional sporting event (to engage in on an individual or group basis for wage or profit) or professional hazardous avocations

36. for expenses related to the use of hypnosis

37. hearing aids and their fitting, except as may be covered under Durable Medical Equipment for Employees only (maximum paid $500 per Plan year)

38. surrogacy, a third-party's expenses in connection with infertility treatment, and sperm or egg storage fees incurred in connection with planning for future treatment.

39. insertion of breast implants (unless in connection with a mastectomy), and any procedure or related series of procedures whereby breast implants are removed and replaced with new implants

40. speech therapy which is not Medically Necessary. Non-Medically Necessary speech therapy may include, but is not limited to, speech therapy provided for educational purposes, articulation disorders, tongue thrust, and stuttering, lisping, abnormal speech development, to change an accent, diplexia or hearing loss

41. Smoking Cessation expenses, including smoking deterrents (see Prescription Drug Plan)

42. massage therapy or rolfing

43. dietician services, except as indicated

44. home attendant

45. non-emergency transportation services

46. prescription drugs (see Prescription Drug Plan) and non-prescription drugs, including vitamins, supplements and oral food supplements

47. treatment or services received as a result of an accidental injury incurred while the Covered Person is engaged in a hazardous activity. Such activities include, but are not limited to, hang gliding, sky diving, ice climbing, ultra-light flying, rock climbing, use of explosives, racing on a motorcycle or boat, travel to countries with advisory warnings, river running and bungee jumping. Additionally, an injury sustained while racing any kind of motorized vehicle and/or operating any kind of motorized vehicle in an organized event will also not be covered by the Plan

48. treatment of learning disorders and/or behavioral problems

49. adoption expenses

50. biofeedback or self-help therapy

51. holistic or homeopathic medicine including services or supplies provided in connection with the treatment

52. hospital services for any non-covered treatment or procedure

53. sex counseling treatment for or related to sexual dysfunction or inadequacies which are not related to organic disease

54. collection of specimen and/or storage fees for future treatment

55. growth hormones (see Prescription Drug Plan)

56. genetic testing and counseling, unless determined to be medically necessary

57. artificial insemination, intra-uterine insemination, in-vitro fertilization, Gamete and Zygote Intra-Fallopian transfer and other methods to bypass fertility or promote pregnancy are not covered

58. elective abortion, unless the mother's life is at risk

59. services not listed or described in this Summary Plan Description

PRESCRIPTION DRUG PLAN

SCHEDULE OF BENEFITS

High Option and Basic Option

Effective 4/1/2021

TYPE OF EXPENSE	RETAIL BENEFITS	MAIL ORDER
Separate Prescription Out-of-Pocket Maximum per Plan Year		
Individual	**$3,300.00**	
Family	**$6,600.00**	
Lowest cost Generic drugs (Tier 1)	$10 copayment (retail 30 day) * $30 copayment (retail 90 day) *	$20.00 copayment (90 day)*
Some Generics and Preferred Brand-Name drugs (Tier 2)	$35 copayment (retail 30 day) * $105 copayment (retail 90 day) *	$70.00 copayment (90 day)*
High cost Generic and Non-Preferred Brand-Name drugs (Tier 3)	$55 copayment (retail 30 day) * $165 copayment (retail 90 day) *	$110.00 copayment (90 day)*
Specialty drugs (Tier 4) (Specialty medications must be obtained directly from the designated Specialty Pharmacy.)	$75.00 copayment for 30 day supply at retail or mail order	
Contraceptive Methods under expanded Women's Preventive Services including oral, injections and devices; includes certain Generics and certain Brand Name Drugs and approved over-the-counter contraceptives (US-Rx Care at 877-200-5533 for a complete list.)	$0 (Requires prescription from physician)	
Certain Preventive OTC and Prescription Drugs under the Patient Protection and Affordable Care Act (ACA). Drugs such as Aspirin, Iron Supplements, Oral Fluorides, Folic Acid, Smoking Cessation and Vaccines based on age, sex and diagnosis are covered. (US-Rx Care at 877-200-5533 for a complete list.)	$0 (Requires prescription from physician)	

*Copayments are waived for certain generic preventive medications for diabetes, hypertension and cholesterol medications.

Refer to the US-Rx Care formulary list to determine the coverage and copayment that will be applied.

Low Option Plan Only

Effective 4/1/2021

TYPE OF EXPENSE	RETAIL BENEFITS	MAIL ORDER
Separate Prescription Out-of-Pocket Maximum per Plan Year		
Individual	**$1,600.00**	
Lowest cost Generic drugs (Tier 1)	$10 copayment (retail 30 day) * $30 copayment (retail 90 day) *	$20.00 copayment (90 day)*
Some Generics and Preferred Brand-Name drugs (Tier 2)	$35 copayment (retail 30 day) * $105 copay (retail 90 day) *	$70.00 copayment (90 day)*
High cost Generic and Non-Preferred Brand-Name drugs (Tier 3)	$55 copayment (retail 30 day) * $165 copayment (retail 90 day) *	$110.00 copayment (90 day)*
Specialty drugs (Tier 4) (Specialty medications must be obtained directly from the designated Specialty Pharmacy.)	$75.00 copayment for 30 day supply at retail or mail order	
Contraceptive Methods under expanded Women's Preventive Services including oral, injections and devices; includes certain Generics and certain Brand Name Drugs and approved over-the-counter contraceptives (US-Rx Care at 877-200-5533 for a complete list.)	$0 (Requires prescription from physician)	
Certain Preventive OTC and Prescription Drugs under the Patient Protection and Affordable Care Act (ACA). Drugs such as Aspirin, Iron Supplements, Oral Fluorides, Folic Acid, Smoking Cessation and Vaccines based on age, sex and diagnosis are covered. (US-Rx Care at 877-200-5533 for a complete list.)	$0 (Requires prescription from physician)	

*Copayments are waived for certain generic preventive medications for diabetes, hypertension and cholesterol medications.

Refer to the US-Rx Care formulary list to determine the coverage and copayment that will be applied.

PLEASE NOTE THAT THIS SCHEDULE IS MERELY A SUMMARY OF SOME FEATURES OF THIS PLAN. ALSO, PLEASE NOTE THAT THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO ANY SERVICES WHICH ARE NOT MEDICALLY NECESSARY, AS DETERMINED BY THE PLAN. IN ADDITION, THE PLAN WILL NEVER MAKE REIMBURSEMENT WITH RESPECT TO SERVICE COSTS WHICH ARE NOT THE PLAN'S ALLOWABLE AMOUNT, AS DETERMINED BY THE PLAN. CERTAIN CHARGES ARE EXCLUDED FROM PLAN COVERAGE AS DESCRIBED LATER IN THIS SUMMARY.

PRESCRIPTION DRUG PLAN

The Prescription Drug plan helps you pay for Prescription Drugs and is administered through US-Rx Care for retail and domestic mail order fills. The Plan also utilizes ScriptSourcing for a voluntary international mail order option on certain Brand-Name medications for a zero copayment.

When you have a prescription filled at any participating pharmacy, you pay a $10.00 copayment per prescription for lower cost generic drugs, a $35.00 copayment for some Generic and Preferred Brand-Name drugs and a $55.00 copayment for high cost Generic and Non-Preferred Brand-Name drugs. There is a mandatory generic requirement, unless a generic drug is not available. If you choose a brand name, you will have to pay the difference between the generic drug and the brand name drug. If your physician requires you to take the Brand-Name drug and writes on the prescription "DAW" or "Dispense as written", you will not be required to pay the difference between the generic drug and the brand name drug. Copayments are waived for certain Generic Preventive fills for diabetes, hypertension and cholesterol medications. The copayments are also waived for certain Contraceptive Methods and Preventive Drugs, to include Over-the-Counter (OTC), under the Patient Protection and Affordable Care Act (ACA).

Generic versions of Brand-Name drugs are reviewed and approved by the FDA (Food & Drug Administration). Generic drugs have the same active ingredients and come in the same strength and dosage form as the Brand-Name drug.

A Brand-Name drug is any approved drug a particular pharmaceutical company has the exclusive right to produce and sell. Over time, companies can lose the patents on particular drugs, opening up the market to generic equivalents. Generic drug equivalents may become available at any time.

The patient should discuss the prescription alternatives with his doctor to determine if a lower cost alternative is available and appropriate for his condition. The patient and the doctor should determine the treatment plan that is most appropriate for the condition. In some cases, this may mean the patient will pay the higher copayment.

When you present your prescription drug card to a participating pharmacy, your cost for a prescription or a refill will be the applicable copayment as indicated in the Schedule of Benefits. For maintenance prescription drugs you can obtain a larger quantity saving you trips to the pharmacy. By using the Mail Order Prescription Drug Program for maintenance medications, you receive a 90 day supply and pay reduced prescription copayment expenses

Specialty Medications - Specialty medications must be obtained directly from the appropriate Specialty pharmacy. These medications include injectables, infused drugs or high dollar oral medications and are provided in a 30 day supply through the appropriate Specialty provider. If you are prescribed a Specialty Medication, your physician will need to contact US-Rx Care to obtain a prior authorization. Once your Specialty medication is authorized, your script will be sent to a Specialty pharmacy. The Specialty pharmacy will contact you to register with the pharmacy and provide your delivery and billing information. The copayment for this level of coverage will be $75.

ScriptSourcing may also be available for certain Specialty drugs and will notify you if this program applies to your medications.

MAIL ORDER PROGRAM

A Mail Order Program for maintenance medications is available. Under this program you can get a 90 day supply of maintenance medications delivered to your home, for reduced copayments of $20.00 for lowest Generic drugs, $70.00 for some Generics and Preferred Brand-Name drugs or $110.00 for high cost Generics and Non-Preferred Brand-Name drugs. There is a zero copayment for Brand-Name medications obtained through ScriptSourcing. Specialty Drugs are subject to a $75 copayment for a 30 day supply. Copayments are waived for certain Generic Preventive Medications, including, generic fills for diabetes, hypertension and cholesterol medications. To register for the Mail Order Program call US-Rx Care NoviXus Member Services Phone: (877) 451-4994 or register online at www.NoviXus.com. US-Rx Care's Physician Dedicated NoviXus Fax Line is: (877) 212-7258.

Information about the US-Rx Care retail, Mail Order and Specialty Medication programs are available by logging on to www.usrxcare.com 7 days a week, 24 hours a day or by calling 877-200-5533.

The Plan provides coverage for the following prescription drugs facilitated by the Plan's vendor, ScriptSourcing:

1. Drugs acquired through ScriptSourcing's Manufacturer's Assistance Program ("MAP"). These are specialty drugs and other higher-cost drugs specifically identified by ScriptSourcing as MAP drugs, that are not on the Plan's formulary list, and that are acquired from their manufacturers, through ScriptSourcing's efforts, at no cost or a lower cost. These drugs are made available to Plan participants with no co-pay. (Any reduced costs paid for these drugs and ScriptSourcing's fees to the employer under the MAP, are considered claims expenses for all purposes of this Plan.)

If an attempt by ScriptSourcing to acquire such a drug from its manufacturer at no cost or a lower cost is unsuccessful, the Plan's Pharmacy Benefit Manager may determine that the drug is medically necessary and in such a case the cost of the drug is considered a claims expense for all purposes of this Plan.

2. Drugs acquired through ScriptSourcing's International Prescription Program ("IPP"). These are drugs specifically identified by ScriptSourcing as internationally-sourced and are made available to Plan participants with no co-pay. The costs of these internationally-sourced drugs and ScriptSourcing's fees to the employer under the IPP are considered claims expenses for all purposes of this Plan.

<u>Other General Prescription Drug Information:</u>

The drug program generally covers drugs and medicines prescribed by a Physician including:

1. contraceptives, oral or other

2. contraceptive devices including IUDs and diaphragms (covered under the Medical Plan)

3. diabetic supplies to include blood glucose monitors (one unit per year), disposable testing agents for blood; urine glucose or acetone and lancet devices

4. insulin and related syringes

5. legend drugs

6. smoking cessation productions. Benefits are available for both over-the-counter and legend (prescription) drugs with a written prescription from you physician

7. fluoride products up to age 18

8. fertility drugs subject to a lifetime maximum of $5000.00

9. generic erectile dysfunction drugs

However, the prescription plan **does not** cover:

1. charges for the administration of any medication

2. therapeutic devices or appliances (e.g. support garments and other nonmedical substances)

3. charges for a prescription refill in excess of the number specified by the Physician, or any refill dispensed after one year from the order of the Physician

4. biological sera, blood or blood plasma

5. drugs or medicines not legally dispensed under federal and/or state law

6. any medication taken by or administered at the place where it is dispensed (i.e. Hospital, rest home, extended care facility, nursing home, etc.)

7. more than a 90-day supply through retail

8. drugs and medicines which can be obtained without a Physician's prescription except certain drugs as noted on the Prescription Schedule of Benefits that require a Physician prescription for coverage

9. experimental drugs

10. prescription drugs which may be obtained without charge under local, state, or federal programs

11. drugs purchased outside the United States that are not legal inside the U.S.

12. medical devices (see the Medical Plan)

13. certain vitamins

14. retin-A, unless Medically Necessary

15. growth hormones unless prior authorization is obtained

16. hair growth agents

17. photo aged skin or anti-wrinkle products

18. brand name erectile dysfunction drugs

19. weight loss drugs

20. compounds/bulk chemicals

21. cough and cold drugs

22. certain prescription drugs are not covered. Refer to the Formulary for a listing of non-covered drugs and covered alternatives

OTHER IMPORTANT INFORMATION
ABOUT YOUR MEDICAL and PRESCRIPTION PLANS

A. Pre-existing Conditions.

There is no pre-existing plan limitation.

B. Coordination of Benefits.

The Plan has been designed to help pay for the cost associated with a sickness and Injury. Because it is not intended to pay benefits greater than your actual health care expenses, the amount of benefits payable under this Plan will be reduced by taking into account any coverage which you or your Dependent have under "other plans".

For purposes of applying the following rules, an allowable expense is any Medically Necessary charge, including deductibles, coinsurance or copays covered in full or in part, previously described as covered in this Summary Plan Description. Plan means health benefits provided by:

1. group insurance coverage,

2. any group coverage through HMOs and any contractual prepayment or indemnity arrangement, group practice, or individual practice coverage,

3. any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans,

4. any insurance for medical payment coverage, personal injury protection, no-fault coverage, uninsured motorist coverage,

5. Medicare, Workers Compensation or other governmental plan as permitted by law,

6. any group plan provided by an educational institution, or

7. self-funded employer health plan.

When a claim is made, the primary plan pays benefits first, without regard to any other plan. The secondary plan (or plans) will calculate its normal plan benefit and then reduce that amount by the amount paid by the primary plan. No plan pays more than it would without the coordination of benefits provision.

Application of Benefits
A plan without a coordination provision is always considered the primary plan. If all plans have such a provision, then the following applies in the order listed to determine the primary plan.

1. The plan of the patient's employer is the primary plan.

2. If a dependent child is covered under one or both parent's plans and is also covered under their spouse's plan, then their spouse's plan is primary.

3. If a dependent child is covered under both parent's plans, the plan of the parent with the earliest birthdate in the calendar year is primary; but if the parents are separated or divorced, their plans pay in this order:

- if a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility;
- the plan of the parent with custody of the child;
- the plan of the stepparent married to the parent with custody of the child;
- the plan of the parent not having custody of the child

4. If none of the above apply, the plan covering the patient the longest is the primary plan based on allowable expenses.

If both this Plan and another plan contain a coordination of benefits clause providing that each plan is secondary, this Plan will pay benefits only for allowable expenses and only in an amount in excess of that which the other plan would have paid if it were the primary plan. For example, if this Plan provides coverage of up to $50 per day for hospitalization for in-patient surgery and the other plan would pay $40 for the same coverage if it were primary, and both this Plan and the other plan provide that they are secondary, this Plan will pay no more than $10 per day for the covered hospitalization.

C. How Medicare Affects Coverage.

If you are an active employee covered under the Plan and you also are eligible for Part A and/or Part B under Medicare, Medicare requires that any Covered Expenses you incur be paid first under the Plan, instead of by Medicare. The Plan also pays first for your covered spouse if your spouse is age 65 or over and if you are an active employee.

Participants with End Stage Renal Disease become entitled for Medicare generally after a three month waiting period. During the next 30 months, if covered under the Plan, the Plan will pay first for Covered Expenses. After the 30 month period, or "coordination" period, Medicare will pay first.

For all other Covered Persons who are not in active service and who are eligible for Medicare, benefits under this Plan will be coordinated with the dollar amount that Medicare will pay. For purposes of these rules, a Covered Person who is eligible for Medicare will be considered to be covered for all benefits available under Medicare (Part A and Part B), regardless or whether or not the person has actually applied for Medicare coverage.

CLAIMS FILING PROCEDURES

When you enroll for coverage, you will receive a Group Health Plan identification card. Please follow the proper procedures when filing a claim. Hospitalizations require precertification. The precertification number is listed on your identification card.

Network Providers--Present your insurance identification card. The card provides billing instructions for the Provider. If you should receive the bill directly from the provider, please contact them and provide your insurance information. Network providers will file claims on your behalf using the information on your insurance identification card.

Out-Of-Network Providers--Present your insurance identification card. The card provides billing instructions for the Provider. If you should receive the bill directly from the provider, please contact them and provide your insurance information.

If the out-of-network provider is not willing to bill your insurance, follow the instructions below.

- Obtain a Health Claim from the Allegeant member portal, myAllegeant.com or from your employer.

- You must complete the form in full, indicating your Member ID number, name, address, the Dependent's name, etc. You must also indicate whether or not you wish to authorize payment directly to the Provider and sign/date the claim form.

- An itemized bill with the following information must be included with your claim submission:

    a) patient's name
    b) diagnosis
    c) type of service or supply
    d) date(s) of treatment
    e) service description and charges
    f) provider name, address, phone number and provider signature

- If you are requesting reimbursement to be made to you, the submitted claim must also include proof of payment a paid receipt (e.g. copy of check, credit card charge, payment receipt by provider office).

Direct Member submission should be done by one of the following:

- **Member Portal: myAllegeant.com - Member Claim Submission**
- **Fax: 410-427-3699**
- **Mail to Address: P.O. Box 981801, El Paso, TX 79998-1801**

Contact the Allegeant Customer Service team at (800) 793-9403 if you have any questions or need assistance.

Please submit claims promptly. All claims must be submitted within 1 year after expenses are incurred. Claims submitted after 12 months will not be considered for payment.

Please note that you must submit Prescription Drug claims directly to US-Rx Care. Obtain these forms from the US-Rx Care website or from Benefits Department at Gray & Son, Inc.

A FINAL COMMENT

Always keep in mind these important points about your Plan and this Summary:

- Covered Persons and beneficiaries should not rely on any oral description of the Plan, because the written terms in the Plan documents always govern. In addition, if any inconsistency exists between the Plan document and this Summary, the Plan document provisions will govern.

- This Summary does not constitute a contract of employment between the Employer and any of its employees or as a right of any employee to be continued in the employment of the Employer.

- The Employer retains the right to amend or terminate the Plan at any time and for any reason. Nothing herein should be construed as a promise of continued benefits.