2025 Employee

Annual Compliance Notices

FOREST RIVER

Compliance Notices

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

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

General Contact: **Dave Besinger**

Phone: **574-367-3268**

Email: **dbesinger@forestriverinc.com**

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

Elkhart, IN 46515

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 11 for more details.

Please refer to the official plan documents for more complete descriptions of the benefit plans. In the event of any inconsistencies or discrepancies between the information provided in this guide and the official plan documents, the official plan documents will prevail. Forest River, Inc. reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time without notice, including making changes to comply with and exercise its options under applicable laws. The authority to make such changes rests with the Plan Administrator. To view the summary plan descriptions and certificates of coverage, visit www.forestriverinc.com. You may contact Human Resources at 574-367-3268 to request a printed copy of the summary plan description and other official plan or program documents, which will be provided at no cost to you.

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact : **Dave Bensinger, Human Resource Director and In-House Counsel**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

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

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

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

  All employees. Eligible employees are:

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

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

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

  ☐ We do not offer coverage.

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

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

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

Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

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

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

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

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance for Independent Laboratory; 20% coinsurance for outpatient services	40% coinsurance	Does not include emergency room or urgent care diagnostic services. Preauthorization is required for certain services. Those services must be pre-certified in order to avoid $250 penalty per occurrence.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required for certain services. Those services must be pre-certified in order to avoid $250 penalty per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cap-rx.com	Generic drugs (Tier 1)	10% up to a maximum copay of $20 / prescription (retail) $25 copay/prescription (extended retail and mail-order)		Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). Rx Deductible does apply. Once the Prescription Drug out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year.
	Preferred brand drugs (Tier 2)	20% up to a maximum copay of $50 / prescription (retail) $50 copay/prescription (extended retail and mail-order)		
	Non-preferred brand drugs (Tier 3)	30% up to a maximum copay of $150 / prescription (retail) $150 copay/prescription (extended retail and mail-order)		
	Specialty drugs (Tier 4)	40% up to a maximum copay of $200 per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization is required for certain services. Those services must be pre-certified in order to avoid $250 penalty per occurrence.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$450 copay/visit, then 20% coinsurance		None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Air ambulance services must be pre-certified in order to avoid $250 penalty per occurrence (excludes 911 initiated emergency transport).

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	$40 copay, deductible does not apply, for office visit; 20% coinsurance for other outpatient services	40% coinsurance	None.
	Habilitation services	$40 copay, deductible does not apply, for office visit; 20% coinsurance for other outpatient services	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per person per calendar year. Preauthorization is required. Services must be pre-certified in order to avoid $250 penalty per occurrence.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for certain services. Those services must be pre-certified in order to avoid $250 penalty per occurrence.
	Hospice services	20% coinsurance	40% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not covered	Applies from birth through age 5.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic Care
- Infertility treatment (except promotion of conception)

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

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

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

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

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

About these Coverage Examples:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY ANNUAL REPORT

For Forest River, Inc. Welfare Benefit Plan

This is a summary of the annual report of the Forest River, Inc. Welfare Benefit Plan, EIN 20-3284366, Plan No. 510, for period 01/01/2023 through 12/31/2023. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

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

Insurance Information

The plan has contracts with Vision Service Plan, ReliaStar Life Insurance Company, Transamerica Life Insurance Company, Paramount Dental, Unum Life Insurance Company Of America, and Provident Life And Accident Insurance Company to pay Dental, Vision, Life Insurance, Short-term Disability, Long-term Disability, Accidental Death and Dismemberment, Long Term Care, Critical Illness, Hospital, and Accident claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2023 were $10,583,673.

Your Rights To Additional Information

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

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

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The

Compliance Notices

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

Notice of Patient Protection

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

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

Women's Health and Cancer Rights Act Notice

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

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

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

Newborns' and Mothers' Health Protection Act Notice

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

Compliance Notices

Michelle's Law Notice

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

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

HIPAA Notice of Privacy Practices

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

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

Genetic Information Nondiscrimination Act of 2008 (GINA)

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

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

Compliance Notices

Mental Health Parity Act Notice

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

Qualified Medical Child Support Order Notice

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

Compliance Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

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

Compliance Notices

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003; TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740; TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

Compliance Notices

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website:https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Compliance Notices

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

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

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

Compliance Notices

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

Compliance Notices

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

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

Contact the person listed below for further information.

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

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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

Effective Date: 1/1/2025

Name of Entity/Sender: Forest River, Inc.

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

Address: 55470 CR 1, Elkhart, IN 46515

Phone Number: 574-367-3268

Distribution Date: 08/16/2024

FOREST RIVER

www.forestriverinc.com

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

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

FOREST RIVER, INC.

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

PPO Plan

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

Information Applicable to Plan 501

Employer Identification Number
20-3284366

The Benefits In This Booklet Are Effective
January 1, 2024

TABLE OF CONTENTS

KEY INFORMATION

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

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

PLAN NAME:
Forest River, Inc. Employee Benefits Plan

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

PLAN NUMBER:
501

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

GROUP NUMBER:
A22100

SPD EFFECTIVE DATE:
January 1, 2024

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

TYPE OF PLAN:
Medical and prescription drugs

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

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

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

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

ELIGIBILITY:

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

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

- Dependents Including:

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

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

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

WORKING SPOUSE COVERAGE PROVISION:

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

ENROLLMENT:

- **Enrollment Waiting Period:**

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

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

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

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

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

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

TERMINATION OF COVERAGE:

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

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

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

IMPORTANT NETWORK CONTACT INFORMATION:

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

PRE-CERTIFICATION PROGRAM

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

The following service require pre-certification:

- **Inpatient Admission:**
  - Acute Inpatient
  - Acute Rehabilitation
  - LTACH (Long Term Acute Care Hospital)
  - Skilled Nursing Facility
  - OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
  - Emergency Admissions (Requires Plan notification no later than 2 business days after admission)
- **Diagnostic Testing:**
  - BRCA Genetic Testing
  - Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
  - Gene Expression Profiling for Managing Breast Cancer Treatment
  - Gene Mutation Testing for Solid Tumor Cancer Susceptibility and Management
  - Genetic Testing for Heritable Cardiac Conditions
  - Genetic Testing for Inherited Diseases
  - Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis
  - Preimplantation Genetic Diagnosis Testing
  - Prostate Saturation Biopsy
  - RET Proto-oncogene Testing for Endocrine Gland Cancer Susceptibility
  - Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders
- **Durable Medical Equipment (DME)/Prosthetics:**
  - Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output
  - Compression Devices for Lymphedema
  - Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
  - Implantable Infusion Pumps
  - Intrapulmonary Percussive Ventilation Device Device
  - Microprocessor Controlled Lower Limb Prosthesis
  - Myoelectric Upper Extremity Prosthetic Devices

- Noninvasive Electrical Bone Growth Stimulation of the Appendicular Skeleton
- Standing Frame
- Ultrasound Bone Growth Stimulation
- Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)

- **Human Organ and Bone Marrow/Stem Cell Transplants:**
  - Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
  - Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
    - Donor Leukocyte Infusion
    - Intrathecal treatment of Spinal Muscular Atrophy (SMA)
    - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
    - (CAR) T-cell immunotherapy treatment
      - Axicabtagene ciloleucel (Yescarta™)
      - Tisagenlecleucel (Kymriah™)
      - Brexucabtagene Autoleucel (Tecartus)
      - lisocabtagene maraleucel (Breyanzi)
      - idecabtagene vicleucel (Abecma)
  - Gene Replacement Therapy (Clear confirmation that the group has excluded the benefit is required. *If the benefit is covered, pre-certification is required) including but not limited to:*
    - Gene Therapy for Ocular Conditions/ Voretigene neparvovec-rzyl (Luxturna™)
    - Gene Therapy for Spinal Muscular Atrophy/ onasemnogene abeparvovec-xioi (Zolgensma®)
- **Other Outpatient and Surgical Services:**
  - Aduhelm (aducanumab)
  - Air Ambulance (excludes 911 initiated emergency transport)
  - Ablative Techniques as a Treatment for Barrett's Esophagus
  - Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
    - Insertion/injection of prosthetic material collagen implants
  - Axial Lumbar Interbody Fusion
  - Balloon Sinus Ostial Dilation
  - Bariatric Surgery and Other Treatments for Clinically Severe Obesity
  - Blepharoplasty, Blepharoptosis Repair, and Brow Lift
  - Bone-Anchored and Bone Conduction Hearing Aids
  - Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures
  - Bronchial Thermoplasty
  - Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
  - Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty

- Cardioverter Defibrillators
- Cervical and Thoracic Discography
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- Corneal Collagen Cross-Linking
- Cosmetic and Reconstructive Services: Skin Related, including but not limited to:
    - Brachioplasty
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- Cosmetic and Reconstructive Services of the Head and Neck, including but not limited to:
    - Facial Plastic Surgery Otoplasty – Rhinophyma
    - Rhinoplasty or Rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)
    - Rhytidectomy (Face lift)
    - Cranial Nerve Procedures
    - Ear or Body Piercing
    - Frown Lines
    - Neck Tuck (Submental Lipectomy)
- Cosmetic and Reconstructive Services of the Trunk and Groin, including but not limited to:
    - Brachioplasty
    - Buttock/Thigh Lift
    - Congenital Abnormalities
    - Lipectomy/Liposuction
    - Repair of Pectus Excavatum/Carinatum
    - Procedures on the Genitalia
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems
- Doppler-Guided Transanal Hemorrhoidal Dearterialization
- Electric Tumor Treatment Field (TTF)
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Functional Endoscopic Sinus Surgery (FESS)
- Home Parenteral Nutrition
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Immunoprophylaxis for respiratory syncytial virus (RSV) / Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Implanted Devices for Spinal Stenosis
- Implantable Infusion Pumps

- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Leadless Pacemaker
- Liposuction/lipectomy
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee and shoulder
- Mastectomy for Gynecomastia
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Mechanical Embolectomy for Treatment of Acute Stroke
- Meniscal Allograft Transplantation of the Knee
- Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Panniculectomy and Abdominoplasty
- Partial Left Ventriculectomy
- Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
- Penile Prosthesis Implantation
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)
- Photocoagulation of Macular Drusen
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing in the Home Setting
- Reduction Mammaplasty
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion, Open
- Sipuleucel-T (Provenge®) Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Surgical and Ablative Treatments for Chronic Headaches

- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Therapeutic Apheresis
- Total Ankle Replacement
- Transanal Hemorrhoidal Dearterialization (THD)
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins
- Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia and Gastroparesis
- Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
- Treatment of Osteochondral Defects
- Treatment of Temporomandibular Disorders
- Treatment of Varicose Veins (Lower Extremities)
- Treatments for Urinary Incontinence
- Vagus Nerve Stimulation
- Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele
- Venous Angioplasty with or without Stent Placement/ Venous Stenting
- Viscocanalostomy and Canaloplasty
- Wearable Cardioverter-Defibrillator

- **Out of Network Referrals:**
  Out of Network Services for consideration of payment at in-network benefit level (may be authorized, based on network availability and/or medical necessity.)
- **Radiation Therapy/ Radiology Services**
  - Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver
  - Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver
  - Intensity Modulated Radiation Therapy (IMRT)
  - MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
  - Proton Beam Therapy
  - Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
  - Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule

Services not requiring pre-certification for coverage, but recommended for pre-determination of medical necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of medical necessity:

1. Procedures, equipment, and/or specialty infusion drugs which have medically necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines.

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

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

2. You or Your Physician must call the number shown on Your member ID card 2 weeks before

or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission. Note: For exceptions, please refer to the section of this document entitled "Compliance Regulations," and see the subheading "Statement of Rights Under the Newborns' and Mothers' Health Protection Act".

3. If You have an emergency admission, pre-certification is required within 48 hours or the next business day following admission.

The following information will be needed to pre-certify:

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

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

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

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

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

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

PENALTY FOR NON-COMPLIANCE:

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

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

SCHEDULE OF COVERED SERVICES AND PROVISIONS

I. MEDICAL CARE BENEFITS:

COVERED SERVICES and PROVISIONS	In-Network	Out-of-Network
Calendar Year Deductible *(taken before benefits are payable unless waived)* *This is an embedded Deductible, meaning each covered family member only needs to satisfy his or her individual Deductible, not the entire Family Deductible, prior to receiving plan benefits. The balance of the Family Deductible can be satisfied by one member or a combination of remaining family members.*	$1,250 per person $2,500 per family	$3,000 per person $6,000 per family
Deductible Carry-Over	Any Covered Services incurred during October, November and/or December which are applied to the Covered Person's Deductible will also "carry-over" to the following year's Deductible.	
Out-of-Pocket Maximum per Calendar Year *(*medical co-pays, Co-Insurance and Deductibles count towards the Out-of-Pocket Maximum) *After amount is reached, 100% level of benefits applies for that Calendar Year.* The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum: • Rx co-pays (see separate Prescription Drug Out-of-Pocket listed below) • "Non-compliance penalty" (for failure to abide by pre-certification requirements). • Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit. *This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits paid at 100%. The balance of the family Out-of-Pocket Maximum can be satisfied by one member or a combination of remaining family members.*	$4,000 per person $8,000 per family	$10,000 per person $20,000 per family
Prescription Drug Out-of-Pocket Maximum per Calendar Year *After amount is reached, the Plan will pay 100% for prescription drugs for the remainder of the Calendar Year.*	$2,500 per person $5,000 per family	
Calendar Year Benefit Maximum	Unlimited	
Precertification Penalty for Non-Compliance: Certain benefits are subject to a $250 penalty per occurrence ***(in addition to Deductible)*** for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section for additional information.	Anthem 1-866-776-4793	
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.	
Coordination of Benefits	If it is determined that this Plan is the secondary payer, benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.	
In-network and out-of-network Deductibles and Out-of-Pocket Maximums are "aggregated," such that Covered Services applied to one also apply to the other.		

II. PRESCRIPTION DRUG BENEFIT:

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

III. PREVENTIVE CARE SERVICES:

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

IV. PHYSICIAN SERVICES:

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

IV. PHYSICIAN SERVICES:

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

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

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

VI. FACILITY SERVICES:

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

VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

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

VIII. TRANSPLANT SERVICES:

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

IX. OTHER COVERED SERVICES:

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

IX. OTHER COVERED SERVICES:

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

IX. OTHER COVERED SERVICES:

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

IX. OTHER COVERED SERVICES:

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

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS **Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.** *Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.*	In-Network	Out-of-Network
Sleep Studies *(In-lab, facility)* *In order to be eligible, the following criteria must be met:* • *Excessive daytime sleepiness* • *Epworth sleepiness scale ≥ 10* • *Witnessed snoring* *Along with one of the following comorbid conditions:* • *Chronic obstructive pulmonary disease* • *Neuromuscular disease* • *Stroke* • *Epilepsy* • *Congestive heart failure* • *BMI > 45* • *Periodic limb movement disorder* • *Narcolepsy* • *Central or complex sleep apnea*	80%	60%
TMJ *(Temporomandibular Joint Dysfunction)* *Limited to $1,000 Maximum paid per Covered Person per Lifetime.* *Benefit does not include charges for orthodontic services.*	80%	60%
Wigs *for hair loss resulting from the treatment of cancer.*	80%	60%
Please Refer to the Pre-Certification Program, Transplants, and Exclusions sections for additional coverage details.		

TRANSPLANTS

PREFERRED TRANSPLANT NETWORK FACILITY:

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

TRANSPLANT EXPENSES

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

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

COVERED TRANSPLANT EXPENSES

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

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

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

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

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

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

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

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

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

- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.

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

Limitations

The transplant coverage does not include charges for:

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

TRAVEL AND LODGING EXPENSES

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

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

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

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

EXCLUSIONS

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

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

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

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

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

DEFINITIONS

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

AIR AMBULANCE

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

AMBULATORY SURGICAL CENTER

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

ANCILLARY SERVICES

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

CALENDAR YEAR

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

CASE MANAGEMENT PROGRAM

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

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

CLAIMS PROCESSOR

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

COMPANY

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

COSMETIC SURGERY/TREATMENT

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

COVERED PERSON / PLAN PARTICIPANT

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

COVERED SERVICES

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

DEDUCTIBLE/CO-INSURANCE

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

DEPENDENTS

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

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

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

DOMESTIC PARTNER

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

ELECTIVE SURGICAL PROCEDURE

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

EMERGENCY ROOM SERVICES

"Emergency Room Services**"** is defined as, with respect to a Medical Emergency, an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, to stabilize the patient. Covered Services provided by an out of network provider or facility that are furnished after a patient has stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Room Services described in the first sentence are furnished will also be considered Emergency Room Services unless the following conditions are satisfied:

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

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

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

EMPLOYEE

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

EMPLOYER

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

ENROLLMENT DATE

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

ESSENTIAL HEALTH BENEFITS

"Essential Health Benefits" include the following general categories and the items and services covered within the categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXTENDED CARE FACILITY

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

FAMILY DEDUCTIBLE

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

GENDER NEUTRAL WORDING

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

GENETIC INFORMATION

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

HOME HEALTH CARE AGENCY

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

HOSPICE

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

HOSPITAL

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

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

HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT

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

HOSPITAL SEMI-PRIVATE

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

ILLNESS

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

INJURY

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

INPATIENT

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

LATE ENROLLMENT

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

LIFETIME

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

MEDICAL EMERGENCY

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

MEDICALLY NECESSARY

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

MEDICARE DRG OR APC REIMBURSEMENT RATE

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

MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES

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

NAMED FIDUCIARY

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

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

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

OPEN ENROLLMENT

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

OUT-OF-NETWORK RATE

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

OUT-OF-POCKET MAXIMUM

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

OUTPATIENT

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

PHYSICIAN

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

PLACEMENT FOR ADOPTION

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

PLAN

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

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

REASONABLE/REASONABLENESS

"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or charges for services or supplies, which are necessary for the care and treatment of Illness or Injury. Determination that charges or services/supplies are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and/or the cause of Injury or Illness necessitating the service(s) and/or charge(s).

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

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

RECOGNIZED AMOUNT

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

RECONSTRUCTIVE BREAST SURGERY COVERAGE

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

RETIREE

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

SECOND SURGICAL OPINION

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

SPECIAL ENROLLMENT

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

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

USUAL AND CUSTOMARY

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

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

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

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a provider of services or supplies. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

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

WAITING PERIOD

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

YOU, YOUR, YOURSELF

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

ELIGIBILITY

WHO IS ELIGIBLE

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

NON-DISCRIMINATION

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

EMPLOYEE COVERAGE

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

DEPENDENT COVERAGE

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

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

INDIVIDUAL EFFECTIVE DATE

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

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

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

OPEN ENROLLMENT

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

LATE ENROLLMENT

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

SPECIAL ENROLLMENT

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

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

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

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

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

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

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

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

TERMINATION OF COVERAGE

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

EMPLOYER POLICIES AND PROCEDURES

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

INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

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

The following definitions are applicable under this provision:

Qualified Individual

A Covered Person who meets the following conditions:

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

B. Either:

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

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition, or Mental/Nervous and Substance Use Disorder Services, and is described in any of the following subparagraphs:

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

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

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

Routine Patient Costs

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

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

Life-Threatening Disease or Condition

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

NETWORK BENEFITS

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

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

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

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

OUT-OF-NETWORK BENEFITS

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

BALANCE BILLING PROTECTIONS

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

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

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

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

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

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

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

PROCEDURES FOR FILING CLAIMS

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

KEY POINTS TO REMEMBER

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

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

FILING A HOSPITAL CLAIM

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

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

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

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

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

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

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

Always retain a copy of the bill for Your records.

THIS PLAN AND MEDICARE

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

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

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

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

APPEALING A CLAIM

CLAIMS PROCEDURES

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

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

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

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

FIRST LEVEL APPEALS PROCEDURE

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

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

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

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

The Plan Administrator's determination:

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

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

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

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

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

SECOND LEVEL (EXTERNAL) APPEALS PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ASSIGNMENT OF BENEFITS

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

CLAIM AUDIT

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

COMPLIANCE

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

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

Same as Employer.

CONTRIBUTIONS

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

ERISA AMENDMENTS

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

FUNDING

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

LIENS

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

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

NO WAIVER

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

PLAN IS NOT A CONTRACT

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

PLAN AMENDMENT, MODIFICATION OR TERMINATION

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

PROHIBITION ON RESCISSION

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

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

REIMBURSEMENT AND SUBROGATION PROVISIONS

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Illness, Injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

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

The Covered Person (including his attorney, and/or legal guardian of a covered minor or incapacitated individual) agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims,

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

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

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

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

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

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

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

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

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

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

RIGHT OF REIMBURSEMENT

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

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

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

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

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

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

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

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

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

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

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

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

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

SEPARATION OF FUNDS

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

WRONGFUL DEATH

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

OBLIGATIONS

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

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

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

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;

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

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

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

If the Covered Person and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or

settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's cooperation or adherence to these terms.

OFFSET

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

MINOR STATUS

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

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

SEVERABILITY

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

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

RIGHTS OF RECOVERY

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

SEVERABILITY

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

SUBMISSION OF CLAIM

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

SUMMARY OF MATERIAL MODIFICATIONS

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

SUMMARY PLAN DESCRIPTION

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

SYSTEM FOR PROCESSING CLAIMS

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

TYPE OF ADMINISTRATION

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

COORDINATION OF BENEFITS (COB)

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

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

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

   If the parent with custody has not remarried:

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

   If the parent with custody has remarried:

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

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

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

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

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

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

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

COMPLIANCE REGULATIONS

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

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

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

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

SOURCE OF INJURY RESTRICTIONS

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

WELLNESS VS. RISK FACTORS

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

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

FAMILY MEDICAL LEAVE ACT (FMLA)

The following applies to companies with 50 or more employees

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

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

MILITARY LEAVES

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

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

GENETIC INFORMATION

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

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

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

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

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

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

HOW IS COBRA COVERAGE PROVIDED?

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

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

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

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

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

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

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

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

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

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

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

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

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

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

ERISA RIGHTS SECTION

As a Plan Participant, You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Services Administration (EBSA).

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for Yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

ENFORCE YOUR RIGHTS

If Your claim for a welfare benefit is denied or ignored, in whole or in part, or if Your coverage was rescinded, You have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, or if Your coverage was rescinded, You may file suit in a state or Federal court, subject to the procedures discussed in the Section "APPEALING A CLAIM" under "GENERAL PROVISIONS." In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Services Administration (EBSA), U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Services Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

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

ISSUED PURSUANT TO

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

1. Disclosure of Summary Health Information to the Plan Sponsor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

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

4. Other Disclosures and Uses of PHI

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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

THE PLAN'S RESPONSIBILITIES

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

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

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

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

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

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

PERMISSIBLE USES AND DISCLOSURES OF PHI

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

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

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

TREATMENT

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

PAYMENT

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

HEALTH CARE OPERATIONS

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose

PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

POTENTIAL IMPACT OF STATE LAW

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

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

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

REQUIRED BY LAW

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

PUBLIC HEALTH ACTIVITIES

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

HEALTH OVERSIGHT ACTIVITIES

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

ABUSE OR NEGLECT

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive

such information, a Covered Person's PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

LEGAL PROCEEDINGS

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

LAW ENFORCEMENT

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

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

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

RESEARCH

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

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

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

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

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

INMATES

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

WORKERS' COMPENSATION

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

EMERGENCY SITUATIONS

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

FUNDRAISING ACTIVITIES

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

GROUP HEALTH PLAN DISCLOSURES

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

UNDERWRITING PURPOSES

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

OTHERS INVOLVED IN YOUR HEALTH CARE

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

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

REQUIRED DISCLOSURES OF PHI

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

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

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

DISCLOSURES TO COVERED PERSONS

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

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

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

BUSINESS ASSOCIATES

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

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

OTHER COVERED ENTITIES

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

PLAN SPONSOR

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

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

SALE OF PHI

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

MARKETING

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

PSYCHOTHERAPY NOTES

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

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

A COVERED PERSON'S RIGHTS

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

RIGHT TO REQUEST A RESTRICTION

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

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

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

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

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

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

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

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

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

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

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

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

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

RIGHT TO INSPECT AND COPY

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

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

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

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

RIGHT TO AMEND

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

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

RIGHT OF AN ACCOUNTING

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

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

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

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

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

RIGHT TO A COPY OF THIS NOTICE

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

COMPLAINTS

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

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

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

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

1. DEFINITIONS

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

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

2. PLAN SPONSOR OBLIGATIONS

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

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

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

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

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

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

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

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

Forest River, Inc.

Your Group Life and Accidental Death and Dismemberment Plan

Identification No. 951841 011

Underwritten by Unum Life Insurance Company of America

7/20/2020

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

TABLE OF CONTENTS

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: January 1, 2016

PLAN YEAR:

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

IDENTIFICATION NUMBER: 951841 011

ELIGIBLE GROUP(S):

Group 1
All full-time salaried employees and hourly Administrative Clerical employees in active employment in the United States with the Employer

Group 2
All other full-time hourly employees, not eligible in another group, in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be regularly scheduled to work at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

For employees entering an eligible group after January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

For You:

Basic Benefit:

Your Employer pays the cost of your coverage.

Additional Benefit:

You pay the cost of your coverage.

For Your Dependents:

You pay the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 180 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

BASIC BENEFIT

Group 1
$50,000

Group 2
$5,000

ADDITIONAL BENEFITS:

Amounts in $10,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $10,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

Group 1 – Basic and Additional Benefits
On the January 1st coincident with or next following the date you have reached age 65, but not age 70, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 65; or
- 65% of the amount of life insurance shown above if you become insured on or after age 65 but before age 70.

There will be no further increases in your amount of life insurance.

On the January 1st coincident with or next following the date you have reached age 70 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 70.

There will be no further increases in your amount of life insurance.

Group 2 – Additional Benefits only
On the January 1st coincident with or next following the date you have reached age 65, but not age 70, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 65; or
- 65% of the amount of life insurance shown above if you become insured on or after age 65 but before age 70.

There will be no further increases in your amount of life insurance.

On the January 1st coincident with or next following the date you have reached age 70 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 70.

There will be no further increases in your amount of life insurance.

MAXIMUM BENEFIT OF ADDITIONAL LIFE INSURANCE FOR YOU:

The lesser of:
- 5 x annual earnings; or
- $250,000.

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Note: You must be enrolled for Additional Life Benefits for yourself in order to elect coverage for your Dependents.

Spouse:

Amounts in $5,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $5,000, if not already an exact multiple thereof.

THE AMOUNT OF YOUR SPOUSE'S LIFE INSURANCE WILL REDUCE BY THE SAME PERCENTAGE AND AT THE SAME TIME YOUR LIFE INSURANCE REDUCES.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR SPOUSE:

$25,000

Children:

Live birth to 6 months:	$1,000
6 months to age 19 or to 25 if a full-time student:	$10,000

THE AMOUNT OF LIFE INSURANCE FOR A DEPENDENT WILL NOT BE MORE THAN 50% OF YOUR AMOUNT OF ADDITIONAL LIFE INSURANCE.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Continuity of Coverage

Portability

Work Life Assistance Program

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. Upon request, your Employer will provide, free of charge, either an electronic or paper copy of the group insurance certificate. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: January 1, 2016

PLAN YEAR:

January 1, 2016 to January 1, 2017 and each following January 1 to January 1

IDENTIFICATION NUMBER: 951841 011

ELIGIBLE GROUP(S):

Group 1
All full-time salaried employees and hourly Administrative Clerical employees in active employment in the United States with the Employer

Group 2
All other full-time hourly employees, not eligible in another group, in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be regularly scheduled to work at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

For employees entering an eligible group after January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

Basic Benefit:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

BASIC BENEFIT

An amount equal to your life amount.

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

Group 1
On the January 1st coincident with or next following the date you have reached age 65, but not age 70, your amount of AD&D insurance will be:
- 65% of the amount of AD&D insurance you had prior to age 65; or
- 65% of the amount of AD&D insurance shown above if you become insured on or after age 65 but before age 70.

There will be no further increases in your amount of AD&D insurance.

On the January 1st coincident with or next following the date you have reached age 70 or more, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to your first reduction; or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 70.

There will be no further increases in your amount of AD&D insurance.

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

<u>Each Qualified Child</u>

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

Continuity of Coverage is available under this plan - refer to the **ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES** for further details.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. Upon request, your Employer will provide, free of charge, either an electronic or paper copy of the group insurance certificate. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

In addition, if you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

HOW WILL UNUM MAKE PAYMENTS?

If your or your dependent's life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

If you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse's death claim will be paid to your surviving spouse's beneficiary.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any **hospital or institution** where treatment was received, including all attending **physicians**.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative's expense, must show:

- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

This plan provides additional life benefits in addition to the basic life benefit and the basic accidental death and dismemberment benefit. When you first become eligible for coverage, you may apply for any number of additional life benefit units, however, you cannot be covered for more than the maximum benefit available under the plan.

Your Employer pays 100% of the cost of your coverage under the basic benefit. You will automatically be covered under the basic benefit at 12:01 a.m. on the date you are eligible for coverage.

You pay 100% of the cost for the additional life benefits. You will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage, if you apply for insurance on or before that date; or
- the date you apply for insurance, if you apply within 31 days after your eligibility date.

If you do not apply for additional life benefits on or before the 31st day after your eligibility date, you can only apply at the next **annual enrollment period** or within 31 days of a **change in status.** Evidence of insurability is required for any amount of insurance.

Coverage applied for during an annual enrollment period will begin at 12:01 a.m. on the later of:

- the first day of the next plan year; or
- the date Unum approves your evidence of insurability form.

Coverage applied for due to a change in status will begin at 12:01 a.m. on the date Unum approves your evidence of insurability form.

WHEN CAN YOU CHANGE YOUR COVERAGE?

You can change your coverage by applying for additional life benefit units only during an annual enrollment period or within 31 days of a change in status.

You can increase your coverage by two benefit units up to the maximum benefit available under the plan or decrease your coverage by any number of benefit units.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

A change in coverage that is made due to a change in status will begin at 12:01 a.m. on the later of:

- the date of the change in status, if you apply on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status.

Changes in coverage must be consistent with the change in status.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness or temporary leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to 12 months.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 3 months following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHEN ARE YOU ELIGIBLE TO ELECT DEPENDENT COVERAGE?

If you elect additional coverage for yourself, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

WHEN ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE?

The date your dependents are eligible for coverage is the later of:

- the date your insurance begins; or
- the date you first acquire a dependent.

WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?

The following dependents are eligible for coverage under the plan:

- Your lawful spouse, including a legally separated spouse. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

- Your unmarried children from live birth but less than age 19. Stillborn children are not eligible for coverage.

- Your unmarried dependent children age 19 or over but under age 25 also are eligible if they are full-time students at an **accredited school**.

- Your unmarried **handicapped** dependent children age 25 or over who became handicapped prior to the child's attainment of age 25.

  Unum must receive proof within 31 days of the date the child is eligible for coverage under this Summary of Benefits, and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

No dependent child may be covered by more than one employee in the plan.

No dependent child can be covered as both an employee and a dependent.

WHEN DOES YOUR DEPENDENT COVERAGE BEGIN?

This plan provides coverage for your dependents. When your dependents first become eligible for coverage, you may apply for:

- any number of life benefit units for your dependent spouse; however your dependent spouse cannot be covered for more than the maximum benefit available under the plan; and
- dependent child(ren) life coverage.

You pay 100% of the cost for your dependent coverage. Your dependents will be covered at 12:01 a.m. on the later of:

- the date your dependents are eligible for coverage, if you apply for insurance on or before that date; or
- the date you apply for dependent insurance, if you apply within 31 days after your dependent's eligibility date.

If you do not apply for dependent coverage on or before the 31st day after your dependent's eligibility date, you can only apply at the next annual enrollment period or within 31 days of a change in status. Evidence of insurability is required for any amount of dependent spouse life insurance. Evidence of insurability is not required for dependent child(ren).

Dependent coverage applied for during an annual enrollment period will begin at 12:01 a.m. on the later of:

- the first day of the next plan year; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

Dependent coverage applied for due to a change in status will begin at 12:01 a.m. on the latest of:

- the date of the change in status, if you apply for dependent coverage on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status; or
- the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required.

WHEN CAN YOU CHANGE YOUR DEPENDENT COVERAGE?

You can change your dependent spouse coverage by applying for additional life benefit units only during an annual enrollment period or within 31 days of a change in status. You can increase your dependent spouse coverage by two benefit units up to the maximum benefits available under the plan or decrease your dependent coverage any number of benefit units. In addition, you can cancel your dependent spouse and/or dependent child coverage.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

A change in coverage due to a change in status will begin at 12:01 a.m. on the later of:

- the date of the change in status, if you apply for dependent coverage on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status.

Changes in coverage must be consistent with the change in status.

WHAT IF YOUR DEPENDENT IS TOTALLY DISABLED ON THE DATE YOUR DEPENDENT'S COVERAGE WOULD NORMALLY BEGIN?

If your eligible dependent is **totally disabled**, your dependent's coverage will begin on the date your eligible dependent no longer is totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.

WHEN WILL CHANGES TO YOUR DEPENDENT'S COVERAGE TAKE EFFECT?

Once your dependent's coverage begins, any increased or additional dependent coverage due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required, provided your dependent is not totally disabled. You must be in active employment or on a covered leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional dependent coverage due to a plan change will begin on the date you return to active employment.

If your dependent is totally disabled, any increased or additional dependent coverage will begin on the date your dependent is no longer totally disabled.

Any decreased coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR DEPENDENT'S COVERAGE END?

Your dependent's coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date you no longer are covered under the additional benefits;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of divorce or annulment.

Unum will provide coverage for a payable claim which occurs while your dependents are covered under the Summary of Benefits or plan.

WILL COVERAGE CONTINUE FOR A HANDICAPPED CHILD INSURED UNDER THE PLAN WHO IS AGE 25 OR OVER?

Coverage will continue for a child age 25 or over who is handicapped, provided:

- the child is currently insured under the plan; and
- the child is unmarried; and
- you are the main source of support and maintenance.

Unum must receive proof within 31 days of the date the child attains 25 and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOU IF UNUM APPROVES YOUR DEPENDENT'S DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your average gross annual income from your Employer for the lesser of the previous 12 full calendar month period just prior to your date of loss or the period of your employment with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from piece rate, commissions, overtime pay, and bonuses but does not include income received from shift differential or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LEAVE OF ABSENCE?

If you become disabled while you are on a covered leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

You must be disabled through your **elimination period**.

Your elimination period is 180 days.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

Also, we will not continue the life insurance premium waiver beyond the Maximum Benefit Period stated below based on your age on the date your disability began.

Year of Birth	**Maximum Benefit Period Social Security Normal Retirement Age**
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943 - 1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months

1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you and your dependents can convert your coverages to individual life policies, without evidence of insurability. The maximum amounts that you can convert are the amounts you and your dependents are insured for under the plan. You may convert a lower amount of life insurance.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you or your dependents no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The person may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You and your dependents may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum for each of you will be the lesser of:

- $10,000; or
- your or your dependent's coverage amounts under the plan less any amounts that become available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you or your dependents die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)

If you or your dependent becomes terminally ill while you or your dependent is insured by the plan, Unum will pay you a portion of your or your dependent's life insurance benefit one time. The payment will be based on 75% of your or your dependent's life insurance amount. However, the one-time benefit paid will not be greater than $500,000.

Your or your dependent's right to exercise this option and to receive payment is subject to the following:

- you or your dependent requests this election, in writing, on a form acceptable to Unum;
- you or your dependent must be terminally ill at the time of payment of the Accelerated Benefit;
- your or your dependent's physician must certify, in writing, that you or your dependent is terminally ill and your or your dependent's life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you or your dependent is not eligible for benefits if:

- you or your dependent is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you or your dependent is required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

Also, premium payments must continue to be paid on the full amount of your dependent's life insurance.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you or your dependent should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your or your dependent's initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance become effective for you or your dependent.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you or your dependent applied for at that time.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you and your dependent(s) if you and your dependent(s) are covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you and your dependent(s) under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you and your dependent(s) are subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:

- the highest amount of life insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for a child will not be more than:

- the highest amount of life insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent's amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and your dependents and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

Your dependents must apply for portable coverage and pay the first premium within 31 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your dependent has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your child has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your child.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you or your dependents were not eligible for portability at the time you or your dependents elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You or your dependents may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

ADDING PORTABLE COVERAGE FOR DEPENDENTS

If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

You may enroll newly acquired dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates);
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or

- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE

If you or your dependent is not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

Covered Losses	**Benefit Amounts**
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
One Hand or One Foot	One Half The Full Amount
Sight of One Eye	One Half The Full Amount

Speech or Hearing	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a **Private Passenger Car**, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a **qualified child**; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:

- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within one year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.
- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- service on full-time active duty in the Armed Forces of any country or international authority.
- travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while:
  - it is being used for test or experimental purposes;
  - you are operating, learning to operate or serving as a member of the crew;
  - it is being operated by or for or under the direction of any military authority.

  This exclusion does not apply to:
  - transport type aircraft operated by the Military Airlift Command of the United States; or
  - similar air transport service of any other country.
- travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned or leased by or on behalf of your Employer.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being **intoxicated**.
- war, declared or undeclared, or any act of war.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

STATE REQUIREMENTS

NOTICE

Questions regarding your Summary of Benefits or coverage should be directed to:

Unum Life Insurance Company of America
Manager Customer Relations
2211 Congress Street
Portland, ME 04122
Toll free: (800) 321-3889, Option 2
Direct: (207) 575-7568
Fax: (207) 575-7963

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

OTHER SERVICES

This service is also available from us as part of your Unum Life Insurance Plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACCREDITED SCHOOL means an accredited post-secondary institution of higher learning for full-time students beyond the 12th grade level.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

ANNUAL ENROLLMENT PERIOD means a period of time before the beginning of each plan year.

CHANGE IN STATUS means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your or your dependent's medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HANDICAPPED means permanently and continuously incapable of self sustaining support by reason of mental or physical incapacity.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means:

- **for purposes of Portability**, a bodily injury that is the direct result of an accident and not related to any other cause.
- **for all other purposes**, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a leave of absence.

LIFE THREATENING CONDITION is a critical health condition that may result in your dependent's loss of life.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and

- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the Summary of Benefits.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUALIFIED CHILD is any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:

- enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
- at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by post tax or employee contributions, as that term is used in the Internal Revenue Code of 1986, as amended.

SICKNESS means:

- **for purposes of Portability**, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- **for all other purposes**, an illness or disease. Disability must begin while you are covered under the plan.

TOTALLY DISABLED means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:

- is confined in a hospital or similar institution;
- is confined at home under the care of a physician for a sickness or injury; or
- has a **life threatening condition**.

Your dependent children:

- are confined in a hospital or similar institution; or
- are confined at home under the care of a physician for a sickness or injury.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia.
Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

For residents of Washington

The definition for **ACTIVE EMPLOYMENT** in the **GLOSSARY** section is amended to include the following:

> A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL?*** (Accelerated Benefit) in the **Life Insurance Benefit Information** section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **Life Insurance Benefit Information** section is amended to remove any exclusion for death caused by suicide.

ERISA

Additional Summary Plan Description Information

If the Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage and the information contained in this document.

Name of Plan:
Forest River, Inc. Employee Benefit Plan

Name and Address of Employer:
Forest River, Inc.
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46515-3030

Plan Identification Number:
a. Employer IRS Identification #: 20-3284366
b. Plan #: 510

Type of Welfare Plan:
Life and Accidental Death and Dismemberment

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benefits issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Forest River, Inc.
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46515-3030
(574) 389-4600

Forest River, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of
Legal Process on the Plan:

Forest River, Inc.
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46515-3030

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 951841 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE

The Employer can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a basic benefit plan; or
- the number of employees insured for all additional benefits is less than 15 lives or 25% of those eligible, whichever is greater; or
- the number of employees insured under a plan decreases by 25%; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to the Summary of Benefits; or

- fewer than 15 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 60 day grace period.

If Unum cancels or modifies the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If a claim is based on your disability

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

If an appeal is based on your disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan

Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or summary of benefits and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or summary of benefits conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Forest River, Inc.

Your Group Short Term Disability Plan

Policy No. 951839 011

Underwritten by Unum Life Insurance Company of America

4/7/2017

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

TABLE OF CONTENTS

BENEFITS AT A GLANCE

SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2016

POLICY NUMBER: 951839 011

ELIGIBLE GROUP(S):

All full-time employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be regularly scheduled to work at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before the plan effective date: First of the month coincident with or next following 2 months of continuous active employment

For employees entering an eligible group after the plan effective date: First of the month coincident with or next following 2 months of continuous active employment

Employees are not eligible for coverage until the waiting period has been completed.

ENROLLMENT:

Employees who are eligible may apply for their coverage at any time within the first 31 days of being eligible.

After 31 days, employees who are eligible may apply for their coverage during any scheduled enrollment period.

You may cancel any coverage for which you make contributions at any time.

EVIDENCE OF INSURABILITY:

Evidence of insurability is required:

- for any amount of coverage applied for more than 31 days after you are first eligible for coverage.
- if you reapply for coverage after it terminates.

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

You must make contributions for your coverage.

Premium contributions are required for your coverage while you are receiving benefit payments under this plan.

ELIMINATION PERIOD:

14 days for disability due to an injury

14 days for disability due to a sickness

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT:

60% of weekly earnings to a maximum benefit of $600 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Your Short Term Disability plan does not cover disabilities due to an occupational sickness or injury.

MINIMUM WEEKLY BENEFIT:

$20

MAXIMUM PERIOD OF PAYMENT:

11 weeks

OTHER FEATURES:

Continuity of Coverage

Pre-Existing: 3/6

Rehabilitation and Return to Work Assistance Benefit

Survivor Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage and if you make contributions to the plan, refer to your confirmation of coverage. The plan includes enrollment, risk management and other support services related to your Employer's benefit program. Upon request, your Employer will provide, free of charge, either an electronic or paper copy of the group insurance certificate.

CLAIM INFORMATION

SHORT TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in this policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your weekly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum weekly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us by offsetting against amounts otherwise payable to you under this policy, or by other legally permitted means.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

Your coverage will begin at 12:01 a.m. on the first of the month coincident with or next following the latest of:

- the date you are eligible for coverage;
- the date you apply for coverage; or
- the date Unum approves your application, if **evidence of insurability** is required.

WHEN CAN YOU APPLY FOR COVERAGE IF YOU DID NOT APPLY OR DECLINED WHEN YOU WERE FIRST ELIGIBLE FOR COVERAGE OR YOU VOLUNTARILY CANCELLED YOUR COVERAGE?

You can apply for coverage only during a **scheduled enrollment period**. Evidence of insurability is required. Unum and your Employer determine when the scheduled enrollment period begins and ends. Your coverage will begin at 12:01 a.m. on the first of the month coincident with or next following the date Unum approves your application.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness or leave of absence, your coverage will begin on the first of the month coincident with or next following the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 3 months following the date your leave of absence begins.

WHAT HAPPENS TO YOUR COVERAGE UNDER THIS POLICY WHILE YOU ARE ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue your coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer has approved your leave in writing.

Your coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical leave of absence, your coverage will be reinstated when you return to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing condition exclusion; or
- require evidence of insurability.

WHEN WILL CHANGES MADE BY YOUR EMPLOYER TAKE EFFECT?

Once your coverage begins, any change requested by your Employer will take effect on the first of the month coincident with or next following the date the change occurs if you are in active employment.

If you are not in active employment due to injury or sickness, or if you are on a covered leave of absence, any change requested by your Employer will begin on the first of the month coincident with or next following the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the effective date of the change.

WHEN DOES YOUR COVERAGE END?

If you choose to cancel your coverage under the policy or a plan, your coverage ends on the first of the month following the date you provide notification to your Employer.

Otherwise, your coverage under the policy or a plan ends on the earliest of the following:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment.

However, as long as premium is paid as required, coverage will continue:

- while benefits are being paid;
- while you are fulfilling the requirements of your elimination period; or
- in accordance with the leave of absence provision of this policy or plan.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you make in a signed application for coverage or evidence of insurability form, or that your Employer makes in the application process, a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

As a basis for doing this, we will use only statements made by the Employer in the application process or statements made by you in a signed application or evidence of insurability form. These statements cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

However, if the Employer gives us information about you that is incorrect, we will:

- use the facts to determine if you have coverage under the plan according to the policy provisions and in what amounts; and
- make a fair adjustment of the premium.

HOW MAY UNUM COMMUNICATE WITH YOU OR YOUR EMPLOYER?

Unum may provide notices, information and other communications to you or your Employer in written, electronic or telephonic form.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

SHORT TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 14 days.

If your disability is the result of a sickness, your elimination period is 14 days.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided you meet the definition of disability.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment weekly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

1. Multiply your weekly earnings by 60%.
2. The maximum **weekly benefit** is $600.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

WHAT ARE YOUR WEEKLY EARNINGS?

"Weekly Earnings" means your average gross weekly income from your Employer for the lesser of the previous 12 full calendar month period just prior to your date of disability or the period of your employment with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from piece rate, commissions, overtime pay, and bonuses but does not include income received from shift differential or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LEAVE OF ABSENCE?

If you become disabled while you are on a covered leave of absence, we will use your weekly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the weekly payment if you are disabled and your weekly **disability earnings**, if any, are less than 20% of your weekly earnings.

If you are disabled and your weekly disability earnings are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount Unum will pay you for each week.

Unum may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from week to week, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 weeks.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.
   - **governmental retirement system**.

2. The amount that you receive:

   - under the mandatory portion of any "no fault" motor vehicle **plan**.
   - under a **salary continuation** or **accumulated sick leave** plan.
   - under Title 46, United States Code Section 688 (The Jones Act).
   - from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

3. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

4. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your **Employer's contribution** to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed

simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable for the same period of disability for which we are paying benefits.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum weekly payment is: $20.

Unum may apply this amount toward an outstanding overpayment.

However, the minimum weekly payment will not be paid if you are receiving salary continuation or accumulated sick leave payments from your Employer.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1 in the deductible sources of income section, we will estimate your entitlement to these benefits and your Short Term Disability payment will be reduced by these estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1 in the deductible sources of income section, and if denied, appeal to all administrative levels Unum feels are necessary;
- provide documentation of your application and/or appeal; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each week up to the **maximum period of payment.** Your maximum period of payment is 11 weeks during a continuous period of disability.

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** and you do not;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury**, however, Unum will cover disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 6 months after your effective date of coverage.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?

1. If your current disability is related to or due to the same cause(s) as your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for 14 consecutive days or less.

   If you return to work on the 15th day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.

2. If your current disability is unrelated to your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for less than 1 full day.

Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the policy provisions.

If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the Unum plan.

SHORT TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your eligible survivor a lump sum benefit equal to the lesser of:

1. $5,000;
2. 3 weeks of your gross disability payment; or
3. the maximum Survivor Benefit allowed by state law.

The Survivor Benefit will be paid if, on the date of your death:

- you were disabled; and
- you were receiving or were entitled to receive payments under the plan for at least 15 consecutive days during this period of disability.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 weeks of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving weekly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 week survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum will provide coverage for you if, as of the effective date of this policy you were covered by the prior policy on the day before the effective date of this policy.

Your coverage is subject to payment of premium and all other terms of this policy. If you are on a leave of absence on the effective date of this policy we will consider your leave of absence to have started on that date and your coverage will continue for the period provided in this policy.

If you have not returned to active employment before your disability begins, your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by an amount for which your prior carrier is liable.

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM OR AFTER YOU BECOME INSURED UNDER THE UNUM PLAN DUE TO A MERGER, ACQUISITION OR AFFILIATION? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the weekly benefit that would have been payable under the terms of the prior plan if it had remained in force; or
b. the weekly payment under the Unum plan.

Your elimination period will be the longer of:

a. the elimination period under the prior plan if it had remained in force; or
b. the elimination period under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $250 per week.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which weekly payments would stop in accordance with this plan.

STATE REQUIREMENTS

NOTICE

Questions regarding your policy or coverage should be directed to:

Unum Life Insurance Company of America
Manager Customer Relations
2211 Congress Street
Portland, ME 04122
Toll free: (800) 321-3889, Option 2
Direct: (207) 575-7568
Fax: (207) 575-7963

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be regularly scheduled to work on average at least the minimum number of hours as described under the minimum hours requirement in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EMPLOYER'S CONTRIBUTION in the context of a retirement plan that is part of any federal, state, county, municipal or association retirement system means any contribution made by your Employer and any contribution made on your behalf which has been picked up by your Employer under Internal Revenue Code Section 414(h)(2) so that it does not constitute taxable income to you.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

OCCUPATIONAL SICKNESS OR INJURY means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your weekly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

SCHEDULED ENROLLMENT PERIOD means a period of time determined by Unum and your Employer.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

WEEKLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

WEEKLY EARNINGS means your gross weekly income from your Employer as defined in the plan.

WEEKLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

YOU means an employee who is eligible for Unum coverage.

ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
Group Short Term Disability Insurance for Employees of Forest River, Inc.

Name and Address of Employer:
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46515-3030

Plan Identification Number:
a. Employer IRS Identification #: 20-3284366
b. Plan #: 510

Type of Welfare Plan:
Disability

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46515-3030
(574) 389-4600

Forest River, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Forest River, Inc.
55470 County Road 1
Elkhart, Indiana
46515-3030

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 951839 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

The Employer can request a policy change. Only an officer of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- our participation requirements are not met, as applicable;
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Employer and/or its employees; or
- a change in federal or state law or regulation substantially impacts the policy or the risks insured.

If Unum cancels or modifies the policy or a plan, for any of the reasons listed above, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

If any premium is not paid during the 60 day grace period, the policy or plan will terminate automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum for premium due for the full period the policy is in force. In the event of termination, the policy or plan may be reinstated only as agreed upon by Unum and the Employer. If Unum agrees to reinstate the policy or plan, such reinstatement will not constitute waiver of the termination provision in the future.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

NOTICE OF PROTECTION PROVIDED BY THE

INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 in basic hospital, medical and surgical or major medical insurance benefits
- $300,000 in disability and long term care insurance
- $100,000 in other types of health insurance

Annuities

- $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- $5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Forest River, Inc.

Your Group Long Term Disability Plan

Policy No. 951840 011

Underwritten by Unum Life Insurance Company of America

10/22/2020

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

TABLE OF CONTENTS

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2016

POLICY NUMBER: 951840 011

ELIGIBLE GROUP(S):

Group 1
Executives and General Managers with 3 or More Years of Service in active employment in the United States with the Employer

Group 2
All other full-time salaried employees, not eligible in another group, with 3 or More Years of Service in active employment in the United States with the Employer

Group 3
Executives and General Managers with at least 1 but less than 3 Years of Service in active employment in the United States with the Employer

Group 4
All other full-time salaried employees, not eligible in another group, with at least 1 but less than 3 Years of Service in active employment in the United States with the Employer

Group 5
Grandfathered hourly employees (Closed Class) in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be regularly scheduled to work at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before January 1, 2016: First of the month coincident with or next following 2 months of continuous active employment

For employees entering an eligible group after January 1, 2016: First of the month following 12 months of continuous active employment

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

Your Employer includes the cost of your Employer-paid coverage in your taxable income.

ELIMINATION PERIOD:

90 days

Accumulation Period: 180 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

Groups 1 and 3
60% of monthly earnings to a maximum benefit of $15,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

Groups 2, 4 and 5
60% of monthly earnings to a maximum benefit of $10,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Groups 1, 2 and 5

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

Groups 3 and 4

Age at Disability	Maximum Period of Payment
Less than age 68	2 years
Age 68	To age 70, but not less than 1 year
Age 69 and over	1 year

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

OTHER FEATURES:

Continuity of Coverage

Conversion

Disability Plus

Minimum Benefit

Pre-Existing: 3/12

Survivor Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. Upon request, your Employer will provide, free of charge, either an electronic or paper copy of the group insurance certificate.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in the policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Group 1
Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

Groups 2, 3, 4 and 5
Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation or of any other gainful occupation for which you are reasonably fitted by education, training, or experience;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum monthly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us by offsetting against amounts otherwise payable to you under this policy, or by other legally permitted means.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness or temporary leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 3 months following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;

- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this. These statements cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

However, if the Employer gives us information about you that is incorrect, we will:

- use the facts to determine if you have coverage under the plan according to the policy provisions and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

Group 1
You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Groups 2 and 5
You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 36 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Groups 3 and 4
You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 90 days.

In addition, if you return to work while satisfying your elimination period, and are no longer disabled, you may satisfy your elimination period within the **accumulation period**. You do not need to be continuously disabled through your elimination period if you are satisfying your elimination period under this provision. If you do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

Your accumulation period is 180 days.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

Groups 1 and 3

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $15,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

Groups 2, 4 and 5

1. Multiply your monthly earnings by 60%.
2. The maximum **monthly benefit** is $10,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

WHAT ARE YOUR MONTHLY EARNINGS?

"Monthly Earnings" means your average gross monthly income from your Employer for the lesser of the previous 12 full calendar month period just prior to your date of disability or the period of your employment with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from piece rate, commissions, overtime pay, and bonuses but does not include income received from shift differential or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LEAVE OF ABSENCE?

If you become disabled while you are on a covered leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the monthly payment if you are disabled and your monthly **disability earnings**, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 24 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 24 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount Unum will pay you each month.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from month to month, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 months.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:

   - a workers' compensation law.
   - an occupational disease law.
   - any other **act** or **law** with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:

   - state compulsory benefit **act** or **law**.
   - group plan sponsored by your Employer.
   - other group insurance plan.

- **governmental retirement system**.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

   - the United States Social Security Act.
   - the Canada Pension **Plan**.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:

   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

8. The amount that you receive under the mandatory portion of any "no fault" motor vehicle **plan**.

9. The amount that you receive under a **salary continuation** or **accumulated sick leave** plan.

10. The amount that you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

Groups 1, 2 and 5

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months

Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

Groups 3 and 4

Age at Disability	Maximum Period of Payment
Less than age 68	2 years
Age 68	To age 70, but not less than 1 year
Age 69 and over	1 year

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

Group 1
- when you are able to work in your regular occupation on a **part-time basis** and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

Groups 2 and 5
- during the first 36 months of payments, when you are able to work in your regular occupation on a **part-time basis** and you do not;
- after 36 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;

- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

Groups 3 and 4
- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** and you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** and disabilities based primarily on **self-reported symptoms** is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

- are not continuous; and/or
- are not related.

However, Unum will send you payments beyond the 24 month period if you meet one of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. If you are not confined to a hospital or institution but become confined for a period of at least 14 days within 90 days after the 24 month period for which you

have received payments, Unum will send payments during the length of the confinement.

Under no circumstances will Unum pay beyond the maximum period of payment as indicated in the **BENEFITS AT A GLANCE** section of your policy.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- attempt to commit or commission of a crime.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?

If you have a **recurrent disability**, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

WHAT INSURANCE IS AVAILABLE IF YOU END EMPLOYMENT? (Conversion)

If you end employment with your Employer, your coverage under the plan will end. You may be eligible to purchase insurance under Unum's group conversion policy. To be eligible, you must have been insured under your Employer's group plan for at least 12 consecutive months. We will consider the amount of time you were insured under the Unum plan and the plan it replaced, if any.

You must apply for insurance under the conversion policy and pay the first quarterly premium within 31 days after the date your employment ends.

Unum will determine the coverage you will have under the conversion policy. The conversion policy may not be the same coverage we offered you under your Employer's group plan.

You are not eligible to apply for coverage under Unum's group conversion policy if:

- you are or become insured under another group long term disability plan within 31 days after your employment ends;
- you are disabled under the terms of the plan;
- you recover from a disability and do not return to work for your Employer;
- you are on a leave of absence; or
- your coverage under the plan ends for any of the following reasons:
  - the plan is cancelled;
  - the plan is changed to exclude the group of employees to which you belong;
  - you are no longer in an eligible group;
  - you end your working career or retire and receive payment from any Employer's retirement plan; or
  - you fail to pay the required premium under this plan.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per **dependent**; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.

DISABILITY PLUS RIDER

WHO IS ELIGIBLE FOR DISABILITY PLUS COVERAGE?

You must be insured under the Unum Long Term Disability (LTD) plan to be eligible for the additional disability coverage described in this Rider. All of the policy definitions apply to the coverage as well as policy provisions specified in this Rider.

WHEN WILL THIS COVERAGE BECOME EFFECTIVE?

You will become insured for Disability Plus coverage on the later of:

- the effective date of this Rider; or
- your effective date under the LTD plan.

Disability Plus coverage will continue as long as the Rider is in effect and you are insured under the LTD plan. There is no conversion privilege feature for Disability Plus coverage.

WHEN WILL YOU BE ELIGIBLE TO RECEIVE DISABILITY PLUS BENEFITS?

We will pay a monthly Disability Plus benefit to you when we receive proof that you are disabled under this rider and are receiving monthly payments under the LTD plan. Disability Plus benefits will begin at the end of the elimination period shown in the LTD plan.

You are disabled under this rider when Unum determines that due to sickness or injury:

- you lose the ability to safely and completely perform 2 **activities of daily living** without another person's assistance or verbal cueing; or
- you have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for your protection or for the protection of others.

HOW MUCH WILL UNUM PAY IF YOU ARE DISABLED?

The Disability Plus benefit is 10% of monthly earnings to a maximum monthly benefit of the lesser of the LTD plan maximum monthly benefit or $5,000.

This benefit is not subject to policy provisions, except for the Total Benefit Cap, which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

WHAT EXCLUSIONS AND LIMITATIONS APPLY TO DISABILITY PLUS?

All of the policy provisions that exclude or limit coverage will apply to this Disability Plus Rider.

For Disability Plus coverage, you will be considered to have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date under this rider; and

- the disability begins in the first 12 months after your effective date under this rider.

You will not receive this benefit for a loss resulting from one of the following conditions, if the loss exists on the effective date of your coverage under this rider:

- a loss of the ability to safely and completely perform any activities of daily living without another person's assistance or verbal cueing; and/or
- a deterioration or loss in intellectual capacity and need for another person's assistance or verbal cueing for your protection or for the protection of others.

WHAT CLAIMS INFORMATION IS NEEDED FOR DISABILITY PLUS?

The LTD claim information section under the policy applies to Disability Plus coverage. We may ask you to be examined, at our expense, by a physician and/or other medical practitioner of our choice. We may also require an interview with you.

WHEN WILL DISABILITY PLUS BENEFIT PAYMENTS END?

Benefit payments will end on the earliest of the following dates:

- the date you are no longer disabled under the Rider;
- the date you become ineligible for monthly payments under the LTD plan;
- the end of the maximum period of payment shown in the LTD plan; or
- the date you die.

No survivor benefits are payable for the Disability Plus coverage.

WHAT IS THE WAIVER OF PREMIUM FOR DISABILITY PLUS?

Premium for the Disability Plus coverage is not required while you are receiving monthly payments under the LTD plan.

STATE REQUIREMENTS

NOTICE

Questions regarding your policy or coverage should be directed to:

Unum Life Insurance Company of America
Manager Customer Relations
2211 Congress Street
Portland, ME 04122
Toll free: (800) 321-3889, Option 2
Direct: (207) 575-7568
Fax: (207) 575-7963

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

GLOSSARY

ACCUMULATION PERIOD means the period of time from the date disability begins during which you must satisfy the elimination period.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

ACTIVITIES OF DAILY LIVING mean:

- Bathing - the ability to wash yourself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing - the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- Toileting - the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
- Transferring - the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - the ability to either:
  - voluntarily control bowel and bladder function; or
  - if incontinent, be able to maintain a reasonable level of personal hygiene.
- Eating - the ability to get nourishment into the body.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

Groups 2, 3, 4 and 5
GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

80% of your indexed monthly earnings, if you are working; or
60% of your indexed monthly earnings, if you are not working.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Group 1
INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working.

Groups 2, 3, 4 and 5
INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

Group 1
MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

Groups 2 and 5
MAXIMUM CAPACITY means, based on your restrictions and limitations:

- during the first 36 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 36 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

Groups 3 and 4
MAXIMUM CAPACITY means, based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a disability payment.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SELF-REPORTED SYMPTOMS means the manifestations of your condition which you tell your physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
Group Long Term Disability Insurance for Employees of Forest River, Inc.

Name and Address of Employer:
Forest River, Inc.
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46515-3030

Plan Identification Number:
a. Employer IRS Identification #: 20-3284366
b. Plan #: 510

Type of Welfare Plan:
Disability Income

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Forest River, Inc.
55470 County Road 1
PO Box 3030
Elkhart, Indiana
46515-3030
(574) 389-4600

Forest River, Inc. is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Forest River, Inc.
55470 County Road 1

PO Box 3030
Elkhart, Indiana
46515-3030

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 951840 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for an Employer paid plan;
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or

- the Employer fails to pay any portion of the premium within the 60 day grace period. If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

If Unum cancels or modifies the policy or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise

discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

YOUR ACCIDENT INSURANCE PLAN

For Employees of
Forest River, Inc.

D4727 (10/19)

GROUP ACCIDENT INSURANCE CERTIFICATE OF COVERAGE
RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 877-236-7564

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CAC2

POLICY EFFECTIVE DATE: November 1, 2019

GOVERNING JURISDICTION: Indiana

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

Benefits are paid for Covered Accidents as defined in the Certificate. The Policy does not constitute comprehensive health insurance coverage (often referred to as "major medical insurance coverage"). In addition, the Policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid under the Policy for Covered Accidents as indemnity insurance and are not intended to cover medical expenses.

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.**

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address.

The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

Exclusions may apply. Please read your Certificate carefully.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.

Carolyn M. Johnson
President

Jennifer M. Ogren
Secretary

TABLE OF CONTENTS

California residents:

If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

Arizona Residents -

Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

Florida Residents -

The benefits of the Policy providing Your coverage are governed primarily by the law of a state other than Florida.

SCHEDULE OF BENEFITS

EMPLOYER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CAC2

ELIGIBLE CLASS(ES)
Employees in Active Employment with the Employer in the United States.
You must be an Employee of the Employer and in an eligible class.
Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT
Employees: 30 hours per week.

ELIGIBILITY WAITING PERIOD
Persons in an eligible class on or before the Policy effective date: End of the month in which you complete a continuous period of 60 days of Active Employment.
Persons entering an eligible class after the Policy effective date: End of the month in which you complete a continuous period of 60 days of Active Employment.

CREDIT FOR PRIOR SERVICE
We will apply any prior period of work with the Employer toward the Eligibility Waiting Period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE
You pay the cost of your coverage.

ACCIDENT BENEFITS

ACCIDENT HOSPITAL CARE

Surgery - open abdominal, thoracic	$3,000
Surgery - exploratory or without repair	$350
Blood, Plasma, Platelets	$900
Hospital Admission	$1,750
Hospital Confinement	$400
Critical Care Unit (CCU) Confinement	$600
Rehabilitation Facility Confinement	$300
Coma	$30,000
Transportation	$700
Lodging	$300
Family Care	$30

ACCIDENT CARE

Initial Doctor Visit	$120
Emergency Room Treatment	$300
Ambulance	
Ground	$400
Air	$1,500
Follow-Up Doctor Treatment	$150
Chiropractic Treatment	$75
Medical Equipment	$375
Physical or Occupational Therapy	$90
Speech Therapy	$75
Prosthetic Device - one	$1,500
Prosthetic Device - 2 or more	$3,000
Major Diagnostic exams	
CT (computerized tomography) or CAT scan (computerized axial tomography)	$500
MRI (magnetic resonance imaging)	$500
EEG (electroencephalogram)	$500
PET (positron emission tomography) scan	$500
Outpatient Surgery	$300
X-ray	$200

COMMON INJURIES

Burns	
2nd degree - at least 36% of the body	$1,750
3rd degree - at least 9 but less than 35 square inches of the body	$10,000
3rd degree - 35 or more square inches of the body	$22,000
Skin Grafts	25% of Burn Benefit
Emergency Dental Work	
Crown	$480
Extraction	$180
Eye Injury	
Surgery	$420
Removal of foreign object	$120
Torn Knee Cartilage	

Surgery with no repair or if cartilage is shaved	$280
Surgical repair	$1,000
Laceration (total of all lacerations)	
treated, no sutures	$150
sutures, up to 2 inches	$150
sutures, 2 to 6 inches	$480
sutures, over 6 inches	$960
Ruptured Disk - surgical repair	$1,500
Tendon/Ligament/Rotator Cuff	
One, surgical repair	$1,500
2 or more, surgical repair	$1,520
Exploratory Arthroscopic Surgery with no repair	$720
Concussion	$300
Paralysis	
Quadriplegia	$45,000
Paraplegia	$22,500

Dislocations (closed & open reduction)	**Closed Reduction /Open Reduction**
Hip Joint	$4,000/$8,000
Knee	$3,000/$6,000
Ankle or Foot Bone(s) other than toes	$1,800/$3,600
Shoulder	$2,200/$4,400
Elbow	$1,500/$3,000
Wrist	$1,500/$3,000
Finger/Toe	$350/$700
Hand Bone(s) other than fingers	$1,500/$3,000
Lower Jaw	$1,500/$3,000
Collarbone	$1,500/$3,000
Partial Dislocations	25% of Closed Reduction Amount

Fractures (closed & open reduction)	**Closed Reduction/ Open Reduction**
Hip	$5,000/$10,000
Leg	$2,800/$5,600
Ankle	$2,500/$5,000
Kneecap	$2,500/$5,000

Foot (excluding toes, heel)	$2,500/$5,000
Upper Arm	$2,750/$5,500
Forearm, Hand, Wrist (except fingers)	$2,500/$5,000
Finger, Toe	$400/$800
Vertebral Body	$4,200/$8,400
Vertebral Processes	$2,000/$4,000
Pelvis (except Coccyx)	$4,000/$8,000
Coccyx	$500/$1,000
Bones of Face (except nose)	$1,400/$2,800
Nose	$750/$1,500
Upper Jaw	$1,750/$3,500
Lower Jaw	$2,000/$4,000
Collarbone	$2,000/$4,000
Rib or Ribs	$600/$1,200
Skull - simple (except bones of face)	$1,900/$3,800
Skull - depressed (except bones of face)	$5,000/$10,000
Sternum	$500/$1,000
Shoulder Blade	$2,500/$5,000
Chip Fractures	25% of Closed Reduction Amount

DEFINITIONS

Accident or **Accidental** means an unforeseen event that results in a bodily Injury.

Active Employment means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.
Temporary and seasonal workers are excluded from coverage.

Certificate means the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

Child or **Children** means your natural or adopted child (from the date of placement or order granting custody) or stepchild, or a child for whom you are a legal guardian, from birth to 26 years of age.

This definition includes your Child age 26 or older who remains dependent on you for support and maintenance because that Child is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished along with any proof of claim.

Child Care Center means any facility or private care that:
- is licensed as such by the state,
- provides non-medical care and supervision for Children, and
- is not operated by you or a member of your immediate family.

Chip Fracture means a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Chiropractor means a person other than you or any family member, who is licensed to diagnose and treat neuromuscular disorders, with an emphasis on treatment through manual adjustment and/or manipulation of the spine, in the state in which treatment is received and providing treatment or advice in accordance with the license.

Coma means a state of unconsciousness for 14 consecutive days due to a Covered Accident with:
- no reaction to external stimuli,
- no reaction to internal needs, and
- the use of life support systems.

Confined or **Confinement** means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or Rehabilitation Facility. There must be a charge for room and board.

Covered Accident means an Accident that:
- occurs on or after your coverage effective date and the effective date of any riders,
- occurs while your coverage is in force, and
- is not excluded by name or specific description in the Policy.

Critical Care Unit means a specifically designated part of a Hospital commonly referred to as an intensive care unit which meets all of the following requirements:
- It provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care.
- It is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- It is permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- It is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis.
- It is assigned a Doctor on a full-time basis.

Critical Care Unit does not include a sub-acute intensive care unit that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward such as a step-down unit.

Dislocation means a separated joint.
- **Open Reduction** of Dislocation = surgical reduction of a completely separated joint.
- **Closed Reduction** of Dislocation = non-surgical reduction of a completely separated joint.
- **Incomplete** Dislocation = the joint is not completely separated.

Doctor means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Emergency Room means a specified area within a Hospital, or a standalone facility licensed as an emergency room with the state, that is designated for emergency care.

Employee means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Eyelid means the moveable fold of skin and muscle that covers the eye.

Fracture means a broken bone that can be seen by x-ray.
- **Open Reduction** of Fracture = surgical.
- **Closed Reduction** of Fracture = non-surgical.

Hospital means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:
- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located.
- It is under the supervision of a medical staff and has one or more Doctors available at all times.
- It provides 24 hours a day service by registered graduate nurses (RNs).
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Injury means a bodily Injury that is the direct result of a Covered Accident and not related to any other cause. Injuries must be independent of Sickness, disease, bodily infirmity and other causes.

Insured Person means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

Occupational Therapist means a person other than you or any family member, who is a licensed health care professional in the state in which treatment is received and providing treatment or advice in accordance with the license. An occupational therapist provides services designed to restore self-care, work, and leisure skills to patients/clients who have specific performance incapacities or deficits that reduce their abilities to cope with the tasks of everyday living. An occupational therapist evaluates and treats problems arising from developmental deficits, physical illness or injury, emotional disorders, the aging process, and psychological or social disability.

Outpatient Surgery means surgical services received at a Hospital or free-standing facility such as a surgical center licensed by the state to render Outpatient Surgery. The surgical service must be performed by a board certified surgical specialist with anesthesia rendered by a separate provider.

Paralysis means spinal cord Injuries sustained in a Covered Accident that result in the loss of use of two or more arms and legs.

- **Paraplegia** = the complete and irreversible Paralysis of both legs.
- **Quadriplegia** = the complete and irreversible Paralysis of both arms and both legs.

Physical Therapist means a person other than you or any family member, who:

- is licensed by the state to practice physical therapy
- performs services within the scope of his/her license, and
- practices according to the Code of Ethics of the American Physical Therapy Association.

Policy means the written group insurance contract between us and the Policyholder.

Policyholder means the Employer to whom the Policy is issued and who sponsors the coverage for its Employees.

Rehabilitation Facility means a free-standing facility providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Doctor knowledgeable and experienced in rehabilitative medicine. A Rehabilitative Facility must meet all the following requirements:

- It is licensed and operated pursuant to law.
- It provides treatment and care for ill and injured persons on an inpatient basis.
- It provides 24 hours a day service by registered graduate nurses (RNs).
- It is not an institution or any part used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Rehabilitation Facility includes a unit of a Hospital with beds set up and staffed and specifically designated for rehabilitative medicine.

Sickness means illness, infection, disease or any other abnormal physical condition that is not due to an Injury. Sickness includes pregnancy, infection and any other abnormal physical condition that is not caused by an Accident.

Speech Therapist means a person other than you or any family member, who is a licensed health care professional in the state in which treatment is received and providing treatment or advice in accordance with the license. The Speech Therapist is trained to evaluate and treat voice, speech, language, or swallowing disorders-eg, hearing impairment, that affect speech (oral-motor-work) and communication.

Spouse means your lawful spouse.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period.

EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you apply for coverage on or before that date.
- The first day of the month following the date you apply for coverage.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

CHANGE OF INSURANCE CARRIERS

If you are not in Active Employment due to Injury or Sickness or Employer-approved nonmedical leave of absence on the date the Employer changes insurance carriers to our Policy, and you were covered under the prior policy at the time the Employer's coverage under our Policy became effective, we will provide continuity of coverage under our Policy. In order for this provision to apply, the prior policy's coverage must be similar to our Policy.

If you are not in Active Employment due to Injury or Sickness or Employer-approved nonmedical leave of absence on the effective date of our Policy, and you would otherwise be eligible to become insured under our Policy, we will provide limited coverage under our Policy. Coverage under this provision will begin on our Policy effective date and will continue until the earliest of the following:

- The date you return to Active Employment.
- The end of any period of continuance or extension provided under the prior policy.
- The date coverage would otherwise end, according to the provisions of our Policy.

Your coverage under this provision is subject to payment of premiums.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. We will reduce our payment by any amount for which the prior carrier is liable.

If your coverage ends under this provision, or if you were not covered under the Employer's prior policy on the date that policy terminated, the EFFECTIVE DATE OF COVERAGE provision under our Policy will apply.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your coverage.
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the Policyholder's grace period, if the Policyholder does not remit premium to us by the end of such period.
- The last day you are in Active Employment.

We will provide coverage for a payable claim that occurs while you are covered under the Policy.

POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:

- There is less than 15% participation of those eligible persons who pay all or part of their premium for the Policy.
- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

We reserve the right to review and terminate all class(es) covered under the Policy if any class(es) cease(s) to be covered.

If the Policyholder fails to pay the full premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least 60 days prior to the termination date.

The Policyholder may terminate the Policy by written notice delivered to us at our home office prior to the termination date. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, the termination will not affect a payable claim.

PORTABILITY

Portability means you have the option to continue your coverage after it would otherwise terminate, if certain conditions are met. You must elect portability before you reach age 70.

To continue your coverage, you must apply for portability and pay the first premium within 31 days of the date your coverage would otherwise terminate due to any of the following:

- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Insured Persons.
- The Policyholder terminates coverage under the Policy for all Insured Persons, and does not replace it with a similar insurance plan.
- You are no longer eligible for coverage under the Policy.

Ported coverage is subject to all the terms of the Policy and this Certificate.

Premiums will be billed directly to you. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time you apply for portability. We may change the portability premium rates at any time upon 60 days written notice to you.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The date you die.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

GRACE PERIOD

The Policyholder has a grace period of 60 days for the payment of any premium due except the first. During the grace period the Policy will remain in force. If full payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance written notice of termination, or if we have given the Policyholder advance written notice of termination as described under the POLICY TERMINATION provision.

If you are on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force. If full payment is not received by us by the end of the grace period, your coverage will automatically terminate at the end of the grace period. A pro rata premium payment is required for any period your coverage was in force during the grace period.

REPRESENTATIONS NOT WARRANTIES

We consider any statements the Policyholder and you make in an application to be representations and not warranties. No statements made by you will be used to reduce or deny any claim or to cancel your coverage unless both of the following are true:

- The statement is in writing and is signed by you.
- A copy of that statement is given to you or your personal representative.

INCONTESTABILITY

Except in the case of fraud, no statement made by you in an application relating to your insurability will be used to contest the insurance for which the statement was made after the coverage has been in force for two years during your lifetime.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

ASSIGNMENT

No assignment of benefits under the Policy is valid, unless otherwise specified in the Policy.

AGENCY

For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

CONSUMER NOTICE

Questions regarding your policy or coverage should be directed to:

ReliaStar Life Insurance Company
877-236-7564

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the jurisdiction where the Policy is issued, is automatically amended to conform to the minimum requirements of such law.

CHANGES TO POLICY OR CERTIFICATE

No agent, representative or employee of Ours or of any other entity may change or waive the terms of the Policy, or of any Certificate or rider issued under it, except in a writing signed by one of Our executive officers and endorsed or attached to the Policy.

If there is a conflict between the terms of this Certificate or any attached rider and the Policy, the Policy controls.

ACCIDENT BENEFITS

ACCIDENT HOSPITAL CARE BENEFITS

We will pay an ACCIDENT HOSPITAL CARE benefit (as shown in the SCHEDULE OF BENEFITS) if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Blood, Plasma, Platelets: Transfusion, administration, cross matching, typing and processing of blood, plasma, platelets administered within 90 days after a Covered Accident. This benefit is payable once per Covered Accident.

Coma: You have been in a Coma for at least 14 days. This benefit is payable once per Covered Accident.

Critical Care Unit Confinement: Confinement in a Critical Care Unit for at least 20 consecutive hours on an inpatient basis as the result of a Covered Accident. The Confinement must begin within 30 days after a Covered Accident. Benefits are payable daily for up to 15 days for a Covered Accident. Benefits are payable for only one Critical Care Unit Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement.

If you are discharged from the Critical Care Unit and then re-Confined within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Critical Care Unit Confinement(s).

Family Care: You are Confined in a Hospital or a Rehabilitation Facility as the result of a Covered Accident, and you have a Child or Children attending a Child Care Center during that Confinement. Benefits are payable daily for up to a total of 45 days of Child Care Center attendance during and immediately following your Confinement. This benefit is payable once per Child per Covered Accident.

Hospital Admission: Admission to a Hospital as a result of a Covered Accident. The admission must begin within 6 months after a Covered Accident. This benefit is payable once per Covered Accident. No benefit is payable for any of the following:

- Emergency Room treatment.
- Outpatient Surgery.
- A stay of less than 20 hours in an observation unit.

Hospital Confinement: Confinement in a Hospital for at least 20 consecutive hours on an inpatient basis as the result of a Covered Accident. The Hospital Confinement must begin within 6 months after a Covered Accident. Benefits are payable daily for up to 365 days for a Covered Accident. Benefits are payable for only one Hospital Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement.

If you are discharged from the Hospital and then re-Confined within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Hospital Confinement(s).

Lodging: Hotel/motel stay by your companion while you are Confined in a Hospital or a Rehabilitation Facility. The Hospital/Facility must be more than 100 miles from your home. The companion must be 18 years of age or older. This benefit is payable for up to 30 days per Covered Accident.

Rehabilitation Facility Confinement: Confinement in a Rehabilitation Facility for 20 consecutive hours on an inpatient basis as the result of a Covered Accident. Benefits are payable daily for each subsequent and continuous day (or portion thereof) of inpatient Rehabilitation Facility Confinement, for up to 90 days per Covered Accident. Benefits are payable for only one Rehabilitation Facility Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement.

If you are released and readmitted to a Rehabilitation Facility within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Rehabilitation Facility Confinement(s).

Surgery: The surgery must take place within 30 days after a Covered Accident. The benefit amount varies based on the type of services received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident. If your surgery meets more than one of the surgery classifications, the higher amount will be payable. No benefit is payable for hernia repair.

Transportation: Transportation for you for special treatment and Confinement in a Hospital or a Rehabilitation Facility. The special treatment must be prescribed by a Doctor and not available locally. The transportation must be more than 100 miles one way. This benefit is payable up to 3 trips per Covered Accident. No benefit is payable for transportation by ground ambulance or air ambulance.

ACCIDENT CARE BENEFITS

We will pay an ACCIDENT CARE benefit (as shown in the SCHEDULE OF BENEFITS) if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Ambulance, Air: Transport by a licensed professional air ambulance company to or from a Hospital or between medical facilities, for treatment of Injuries received as the result of a Covered Accident. The transport must be within 48 hours after the Covered Accident. This benefit is payable once per Covered Accident.

Ambulance, Ground: Transport by a licensed professional ambulance company to or from a Hospital or between medical facilities, for treatment of Injuries received as the result of a Covered Accident. The transport must be within 90 days after the Covered Accident. This benefit is payable once per Covered Accident.

Chiropractic Treatment: Treatment must be received by a Chiropractor in a Chiropractor's office. The treatment must begin within 90 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 6 times per Covered Accident.

Emergency Room Treatment: Examination and treatment by a Doctor in an Emergency Room within 7 days after a Covered Accident. This benefit is payable once per Covered Accident. **Exception:** If you are also eligible for an Initial Doctor Visit benefit, the Initial Doctor Visit benefit amount will be subtracted from the Emergency Room treatment benefit.

Follow-Up Doctor Treatment: Follow-up treatment by a Doctor must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is only available if you are eligible for the Initial Doctor Visit benefit or the Emergency Room treatment benefit. This benefit is payable up to 6 times per Covered Accident.

Initial Doctor Visit: Examination and treatment by a Doctor within 14 days after a Covered Accident. This benefit is payable once per Covered Accident. **Exception:** If you are also eligible for an Emergency Room treatment benefit, the Initial Doctor Visit benefit will be subtracted from the Emergency Room treatment benefit.

Major Diagnostic Exams: A major diagnostic exam must be prescribed by a Doctor and must occur within 6 months after the Covered Accident. This benefit is payable once per Covered Accident.

Medical Equipment: The medical equipment must be prescribed by a Doctor and use must begin within 6 months after the Covered Accident. This benefit is payable once per Covered Accident. The types of eligible equipment are:

- Crutches.
- Wheelchair.
- Back Brace.
- Leg Brace.
- Walker.

Outpatient Surgery: Miscellaneous surgery that is not covered by any other specific sum Injury benefit. The surgery must take place within 6 months after a Covered Accident. Only one surgery benefit is payable per 24-hour period even though more than one surgical procedure may be performed. Only one surgery benefit is payable per Covered Accident. No benefit is payable for hernia repair.

Physical or Occupational Therapy: Therapy must be prescribed by a Doctor and provided by a Physical Therapist or by an Occupational Therapist in an office or Hospital or a Rehabilitation Facility on an inpatient or outpatient basis. The therapy must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 6 times per Covered Accident.

Prosthetic Device: You receive a prosthetic device prescribed by a Doctor for use following the loss of use of a hand, a foot or the sight of an eye. The prosthetic device must be received within one year of a Covered Accident. The benefit amount varies based on the number of prosthetic devices received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident. Prosthetic devices do not include any of the following:

- Hearing aids.
- Dental aids including false teeth.
- Eye-glasses.
- Artificial joints.
- Cosmetic prostheses such as hair wigs.

Speech Therapy: Therapy for the treatment of speech and communication disorders. The approach used varies depending on the disorder. It may include physical exercises to strengthen the muscles used in speech (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

Speech therapy must be prescribed by a Doctor and provided by a Speech Therapist in an office or Hospital or a Rehabilitation Facility on an inpatient or outpatient basis. The therapy must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 6 times per Covered Accident.

X-ray: An x-ray must be prescribed by a Doctor. This benefit is payable within 90 days of a Covered Accident and is payable once per Covered Accident.

COMMON INJURIES BENEFITS

We will pay a COMMON INJURIES benefit (as shown on the SCHEDULE OF BENEFITS) if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Burns: The burn must be treated by a Doctor within 72 hours after a Covered Accident. The benefit amount varies based on the burn classification (refer to the SCHEDULE OF BENEFITS). If your burn meets more than one of the burn classifications, the higher amount will be payable. This benefit is payable once per Covered Accident.

Concussion: The concussion must be diagnosed by a Doctor within 72 hours after a Covered Accident. The diagnosis must be confirmed by the use of some type of medical imaging procedure; i.e. x-ray, CT scan or MRI.

Dislocations: The Dislocation must be diagnosed by a Doctor within 90 days after a Covered Accident. The Dislocation must require Open or Closed Reduction by a Doctor. The benefit amount will vary based on the type of services received.

- If the reduction is done without anesthesia, the benefit will be reduced to 25% of what would have been paid for a Closed Reduction of the same joint.
- If the Dislocation is incomplete, the benefit will be reduced to 25% of what would have been paid for a Closed Reduction of the same joint.

If you receive more than one Dislocation in the same Covered Accident, a benefit is payable for all Dislocations. However, the benefit will be no more than two times the benefit amount for the joint involved which pays the highest benefit amount.

If you receive a Dislocation and a Fracture in the same Covered Accident, a benefit is payable for both. However, the benefit will be no more than two times the amount for the bone or joint involved which pays the highest benefit amount.

If you receive a Dislocation or a Fracture and you tear, rupture or sever a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit is payable. The benefit payable will be the largest of either the Dislocation, the Fracture or the tendon/ligament/rotator cuff benefit.

This benefit is payable once per Covered Accident. **Exception:** Subsequent Dislocations of the same joint in a different Covered Accident are not covered.

Emergency Dental Work: Natural teeth must be damaged due to a Covered Accident and either extracted or repaired by the placement of a crown. The benefit amount varies based on the type of services received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident regardless of the number of teeth involved.

Eye Injury: The eye Injury must be treated by a Doctor within 90 days after a Covered Accident. The Injury must require surgery or the removal of a foreign object by a Doctor. The benefit amount varies based on the type of services received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident. No benefit is payable for examination with anesthesia or for an Injury to the Eyelid.

Fractures: The Fracture must be diagnosed by a Doctor within 90 days after a Covered Accident. The Fracture must require Open or Closed Reduction by a Doctor. If the Doctor diagnoses the Fracture as a Chip Fracture, the benefit will be reduced to a percentage of what would have been paid for a Closed Reduction of the same bone. The benefit amount varies based on the type of services received (refer to the SCHEDULE OF BENEFITS).

If you receive more than one Fracture in a Covered Accident, a benefit is payable for all Fractures. However, the benefit will be no more than two times the benefit amount listed for the bone which pays the highest benefit amount.

If you receive a Fracture and a Dislocation in the same Covered Accident, a benefit is payable for both. However, the benefit will be no more than two times the amount for the bone or joint involved which pays the highest benefit amount.

If you receive a Fracture or a Dislocation and you tear, rupture or sever a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit is payable. The benefit payable will be the largest of either the Fracture, the Dislocation or the tendon/ligament/rotator cuff benefit.

Laceration: A laceration is a cut. The laceration must be treated by a Doctor within 72 hours after a Covered Accident. The benefit amount will be based on the total length of all lacerations requiring repair that are received in any one Covered Accident. If the laceration is severe enough to require stitches but the Doctor chooses to repair it another way, the benefit will be determined as if the laceration was stitched. This benefit is payable once per Covered Accident.

Paralysis: Paralysis must be confirmed by a Doctor and based on documented evidence of the Injury that caused the Paralysis. The duration of the Paralysis must be at least 30 days and expected to be permanent. The benefit amount varies based on the degree of Paralysis (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident.

Ruptured Disk: You must receive surgical repair of a ruptured disk. The ruptured disk must be treated by a Doctor within 90 days after a Covered Accident. Surgical Repair by a Doctor is required within one year after the Covered Accident. This benefit is payable once per Covered Accident.

Skin Graft: The skin graft is for a burn for which a benefit was paid under the burn benefit in this section. This benefit is payable once per Covered Accident.

Tendon/Ligament/Rotator Cuff: The tendon, ligament or rotator cuff must be torn, ruptured or severed and repaired through surgery within 90 days after a Covered Accident. The benefit amount varies based on the number of repairs required and the services received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident.

If you receive a Dislocation or a Fracture and you tear, rupture or sever a tendon/ligament/rotator cuff in the same Covered Accident, only one benefit is payable. The benefit payable will be the largest of either the Dislocation, the Fracture or the tendon/ligament/rotator cuff benefit.

Torn Knee Cartilage: You must receive surgical repair of torn knee cartilage. The Injury must be treated by a Doctor within 60 days after a Covered Accident. Surgical repair of the tear must occur within 6 months after the Covered Accident. The benefit amount varies based on the type of service received (refer to the SCHEDULE OF BENEFITS). This benefit is payable once per Covered Accident.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal activity.
- An Accident while you are operating a motorized vehicle while intoxicated. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism, drug abuse, or misuse of alcohol or taking of drugs, other than under the direction of a Doctor.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.
- Work for pay, profit or gain.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require you to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits are payable to you unless otherwise specified. Once a claim has been approved, we will make payment immediately upon receipt of proof of claim. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children, in equal shares.
3. Your grandchildren, in equal shares.
4. Your parents, in equal shares.
5. Your siblings, in equal shares.
6. Your estate.

If a survivor entitled to receive a payment dies before receiving it, we will make payment to that person’s estate.

"Spouse” in this provision means your lawful spouse.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

BENEFIT PAYMENTS

Benefits are payable to You unless otherwise specified. Once a claim has been approved, We will make payment immediately upon receipt of proof of claim. Any accrued benefits that are payable at the time of Your death will be paid to Your estate.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

SPOUSE ACCIDENT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

ACCIDENT BENEFITS

The benefit amounts for your Spouse are the same as the benefit amounts for you as shown in the SCHEDULE OF BENEFITS section of the Certificate, based on your Spouse's Covered Accident.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

Spouse means your lawful spouse.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Spouse is eligible under this Rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

EFFECTIVE DATE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you apply for Spouse coverage on or before that date.
- The first day of the month following the date you apply for Spouse coverage.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical Leave of Absence and paid time off for nonmedical-related absences.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse can apply to continue Spouse coverage if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, your Spouse must be under age 70 and your Spouse must apply for portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse is approved by us for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under this rider. Ported coverage is subject to all the terms of the Policy and Certificate.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

ACCIDENT BENEFITS

The benefits for your Spouse are the same as the benefits for you as shown in the ACCIDENT BENEFITS section of the Certificate, based on your Spouse's Covered Accident.

Only one family care benefit is payable per Child if you and your Spouse are simultaneously Confined in a Hospital or a Rehabilitation Facility.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal activity.
- An Accident while your Spouse is operating a motorized vehicle while intoxicated. Intoxication means your Spouse's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism, drug abuse, or misuse of alcohol or taking of drugs, other than under the direction of a Doctor.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.
- Work for pay, profit or gain.

CLAIMS

Additional general claim provisions are described in the CLAIMS section of the Certificate.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Spouse's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PHYSICAL EXAMINATION

We may require your Spouse to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

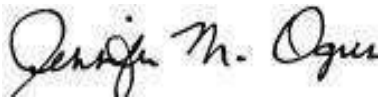
BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For Portability Following Death or Divorce, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

CHILDREN'S ACCIDENT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

ACCIDENT BENEFITS

The benefit amounts for your Children are the same as the benefit amounts for you as shown in the SCHEDULE OF BENEFITS section of the Certificate, based on your Child's Covered Accident.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

Child or **Children** means a child from birth but less than 26 years of age who is one of the following:

- Your natural or adopted child (from the date of placement or order granting custody).
- Your stepchild.
- A child for whom you are a legal guardian.
- Your foster child.

The child must also meet all of the following conditions:

- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing.

Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

Spouse means your lawful spouse.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If both you and your Spouse are covered under the Policy as an Employee, then only one, but not both, may cover the same Children under this rider. If the parent who is covering the Children stops being insured as an Employee then the other parent may apply for Children's coverage under this rider within 60 days.

EFFECTIVE DATE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Children are eligible for coverage, if you apply for Children's coverage on or before that date.
- The first day of the month following the date you apply for Children's coverage.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical Leave of Absence and paid time off for nonmedical-related absences.

TERMINATION

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The date the Child reaches age 26, unless he/she is disabled as defined under the definition of Child. Coverage of a disabled Child ends when the Child is no longer dependent on you for support and maintenance.

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date you no longer have any eligible Children covered under this rider. See the PORTABILITY FOLLOWING DEATH provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH

If you die and your Spouse is approved by us for portability under the Spouse Accident Rider, then this rider can be continued under your Spouse's coverage. Following portability of this rider, Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date there are no longer any eligible Children covered under this rider.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

ACCIDENT BENEFITS

The benefits for your Children are the same as the benefits for you as shown in the ACCIDENT BENEFITS section of the Certificate, based on your Child's Covered Accident. Benefits are payable for each covered Child.

No family care benefit is payable for your Child's Covered Accident.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal activity.
- An Accident while your Child is operating a motorized vehicle while intoxicated. Intoxication means your Child's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism, drug abuse, or misuse of alcohol or taking of drugs, other than under the direction of a Doctor.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.
- Work for pay, profit or gain.

CLAIMS

Additional general claim provisions are described in the CLAIMS section of the Certificate.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Child's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PHYSICAL EXAMINATION

We may require your Child to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

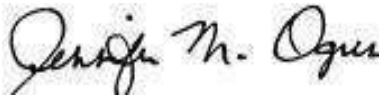
BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For Portability Following Death, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

DEFINITIONS

Covered Person means:

- You, if you are covered for Accident insurance under the Policy.
- Your Spouse who is covered under your Spouse Accident Rider.
- Your Children who are covered under your Children's Accident Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Accident coverage effective date.

EFFECTIVE DATE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

CHANGE OF INSURANCE CARRIERS

The CHANGE OF INSURANCE CARRIERS provision in the Certificate is revised to include an Employee whose coverage was being continued under a similar continuation provision of the Employer's prior policy on the date the Employer changes insurance carriers to our Policy.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Accident insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence

then insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during an FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

Sickness or Injury

If you are on a Leave of Absence due to your sickness or injury, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 9 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

Military Leave

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) and applicable state law, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 3 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.

- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy in Active Employment.
- The date of your death.
- The date you become covered under another group Accident insurance policy as an employee or member.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, insurance under the Policy will stay in force only if all of the following conditions are met:
- Accident insurance is in force for Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during an FMLA or State FML Leave of Absence, and you return to Active Employment immediately following the end of the FMLA or State FML Leave of Absence and while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated effective the date you return to Active Employment. The amount(s) of coverage will be subject to the SCHEDULE OF BENEFITS in effect on the date you return to Active Employment. We will not apply a new Eligibility Waiting Period for the same or lesser amount(s) of coverage.

If coverage is not continued during your Leave of Absence for active military service, and you return to Active Employment while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated in accordance with USERRA and applicable state law.

If coverage is not continued during any other period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Employees under the Policy, then the terms of the Certificate and riders will apply.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Carolyn M. Johnson
President

Jennifer M. Ogren
Secretary

WELLNESS BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

WELLNESS BENEFIT

You:	$100
Your Spouse:	$100
Your Children:	50% of your wellness benefit amount, to a maximum of $200 for all Children in one calendar year

DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

Covered Person means:

- You, if you are covered for Accident insurance under the Policy.
- Your Spouse who is covered under your Spouse Accident Rider.
- Your Children who are covered under your Children's Accident Rider.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.

EFFECTIVE DATE

Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION

This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Accident Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Accident Rider terminates.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce and your Spouse is approved by us for portability under the Spouse Accident Rider, then this rider can also be continued under your Spouse's coverage.

ASSIGNMENT

At the time of claim under this rider, you can assign the payment of a benefit under this rider to a third party who is not the Policyholder.

BENEFITS

We will pay you a wellness benefit (shown on the SCHEDULE OF BENEFITS) if a Covered Person has a health screening test.

A wellness benefit is payable only once per calendar year per Covered Person.
Health screening tests include, but are not limited to:

- Blood test for triglycerides
- Pap smear or thin prep pap test;
- Flexible sigmoidoscopy
- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography
- PSA (prostate cancer)
- Electrocardiogram (EKG)
- Routine Eye exam
- Routine dental exam
- Well child/preventive exams through age 18
- Biometric screenings

EXCLUSIONS

The EXCLUSIONS section of the Certificate and riders does not apply to this rider.

CLAIMS

Additional general claims provisions are described in the CLAIMS section of the Certificate. The PHYSICAL EXAMINATION provision does not apply to this rider.

FILING A CLAIM

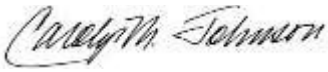
The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

BENEFIT PAYMENTS

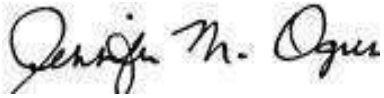
Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment immediately upon receipt of due written receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For Portability Following Death or Divorce, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401



Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CAC2

This rider is made a part of the Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

AD&D BENEFITS

Accidental Death

You:	$40,000
Your Spouse:	$15,000
Your Children:	$8,000

Common Carrier

You:	$85,000
Your Spouse:	$40,000
Your Children:	$20,000

Dismemberment

Loss of both hands or both feet or the sight in both eyes:	$24,000
Loss of one hand or one foot AND the sight in one eye	$18,000
Loss of one hand AND one foot	$18,000
Loss of one hand OR one foot	$10,000
Loss of two or more fingers or toes	$1,500
Loss of one finger or toe	$1,000

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate and riders regarding medical conditions and eligibility apply to each Covered Person.

Common Carrier means any commercial transportation that operates on a regularly scheduled basis between predetermined points or cities.

Covered Person means:

- You, if you are covered for Accident insurance under the Policy.
- Your Spouse who is covered under your Spouse Accident Rider.
- Your Children who are covered under your Children's Accident Rider.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.

EFFECTIVE DATE

Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION

This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Accident Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Accident Rider terminates.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce and your Spouse is approved by us for portability under the Spouse Accident Rider, then this rider can also be continued under your Spouse's coverage.

REPRESENTATIONS NOT WARRANTIES

We consider any statements you make in an application to be representations and not warranties. No statements made by you will be used to reduce or deny any claim or to cancel your coverage unless both of the following are true:

- The statement is in writing and is signed by you.
- A copy of that statement is given to you, your beneficiary or your personal representative.

AD&D BENEFITS

We will pay an AD&D benefit (refer to the SCHEDULE OF BENEFITS) if a Covered Person receives any of the services or meets any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur, and the loss resulting from the Injury must begin, while the Covered Person is covered under this rider.

Accidental Death: Injuries received in a Covered Accident cause a Covered Person's death within 90 days after the Covered Accident. Your benefit is payable to your named Accidental Death beneficiary. If there is no named beneficiary, benefits will be paid according to the BENEFIT PAYMENTS provision in the Certificate. Your Spouse's and Child's benefit is payable to you. Note: No Accidental Death benefit is payable if the Covered Person is eligible for the Common Carrier benefit.

Common Carrier: Injuries received in a Covered Accident while a Covered Person is a fare paying passenger in a Common Carrier cause the Covered Person's death within 90 days after the Covered Accident. Your benefit is payable to your named Accidental Death beneficiary. If there is no named beneficiary, benefits will be paid according to the BENEFIT PAYMENTS provision in the Certificate. Your Spouse's and Child's benefit is payable to you.

Dismemberment: A benefit is payable to you if a Covered Person's loss (as described below) occurs within 90 days after a Covered Accident. The benefit amount varies based on the loss (refer to the SCHEDULE OF BENEFITS). The types of eligible loss under this benefit are limited to the following:

- Loss of both hands.
- Loss of both feet.
- Total and permanent loss of sight in both eyes.
- Loss of one hand or one foot AND permanent loss of sight in one eye.
- Loss of one hand AND one foot.
- Loss of one hand OR one foot.
- Loss of two or more fingers or toes.
- Loss of one finger OR one toe.

"Loss" means the physical loss of:

- A hand: the hand is removed through or above the wrist joint.
- A foot: the foot is removed through or above the ankle joint.
- Sight in an eye: total and permanent loss of sight.
- A finger: the finger is removed at the joint proximate to the first interphalangeal joint where it is attached to the hand.
- A toe: the toe is removed at the joint proximate to the first interphalangeal joint where it is attached to the foot.

If a Covered Person loses a finger or toe and within 90 days as the result of the same Covered Accident loses a hand or foot on the same side of the body, the benefit amount payable for the loss of the finger or toe will be subtracted from the benefit payable for the loss of the hand or the foot.

If an Accident benefit is payable after laceration repair of a finger, toe, hand, foot or eye and that body part is later lost due to the same Covered Accident, the amount of the laceration repair benefit will be subtracted from the dismemberment benefit.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal activity.
- An Accident while the Covered Person is operating a motorized vehicle while intoxicated. Intoxication means the Covered Person's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism, drug abuse, or misuse of alcohol or taking of drugs, other than under the direction of a Doctor.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Sickness or declining process caused by a Sickness.
- Work for pay, profit or gain.

CLAIMS

Additional general claim provisions are described in the CLAIMS section of the Certificate.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PHYSICAL EXAMINATION

We may require the Covered Person to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you or your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

AUTOPSY

We may require an autopsy in case of death, at our expense, where it is not prohibited by law.

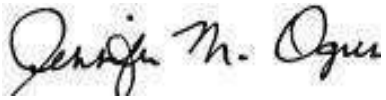
BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For Portability Following Death or Divorce, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 122
Minneapolis, Minnesota 55440-0122

Plan Name, Number and Name and Address of Plan Sponsor:
Forest River, Inc. Welfare Benefit Plan
71143-8CAC2
Forest River, Inc.
900 County Road 1
Elkhart, IN 46515

Name, Address, and Telephone Number of the Plan Administrator:
David Besinger, HR Manager/In-House Counsel
900 County Road 1
Elkhart, IN 46515
574-389-4600

Identification Numbers
IRS Employer Identification Number: 20-3284366
Plan Number: 510

Agent for Legal Process: Plan Administrator

Trustees: None

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Premiums are 100% Employee paid.

Plan Year: January 1 through December 31

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant also the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, 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.

YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of
Forest River, Inc.

D4732 (10/19)

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 877-236-7564

POLICYHOLDER:	Forest River, Inc.
GROUP POLICY NUMBER:	71143-8CCI2
POLICY EFFECTIVE DATE:	November 1, 2019
GOVERNING JURISDICTION:	Indiana

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

Benefits are paid for Critical Illnesses as defined in the Certificate. The Policy does not constitute comprehensive health insurance coverage (often referred to as "major medical insurance coverage"). In addition, the Policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid under the Policy for Critical Illnesses as indemnity insurance and are not intended to cover medical expenses.

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate replaces any other Certificates we may have given you for the same level of coverage under the Policy.

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

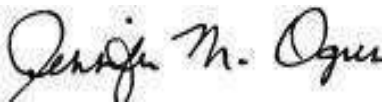
For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address. The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

Please read your Certificate carefully.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.

Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

TABLE OF CONTENTS

Arizona Residents:
Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

California residents:
If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

Florida residents:
The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.

SCHEDULE OF BENEFITS

EMPLOYER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CCI2

ELIGIBLE CLASS(ES)
All Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.
Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT
Employees: 30 hours per week.

ELIGIBILITY WAITING PERIOD
Persons in an eligible class on or before the Policy effective date: End of month in which you complete a continuous period of 60 days of Active Employment.

Persons entering an eligible class after the Policy effective date: End of month in which you complete a continuous period of 60 days of Active Employment.

CREDIT FOR PRIOR SERVICE
We will apply any prior period of work with the Employer toward the Eligibility Waiting Period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE
You pay the cost of your coverage.

BENEFIT AMOUNT

Choice of $5,000 or $10,000 or
$15,000 or $20,000 or $25,000 or
$30,000

CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	2 times the BENEFIT AMOUNT
Major Organ Transplant	100%	2 times the BENEFIT AMOUNT
Coronary Artery Bypass	25%	2 times the BENEFIT AMOUNT
Carcinoma in Situ (CIS)	25%	2 times the BENEFIT AMOUNT

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Coronary Angioplasty	10%	2 times the BENEFIT AMOUNT

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	2 times the BENEFIT AMOUNT
Skin Cancer	10%	2 times the BENEFIT AMOUNT
Bone Marrow Transplant	25%	2 times the BENEFIT AMOUNT
Stem Cell Transplant	25%	2 times the BENEFIT AMOUNT

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight, Hearing or Speech	100%	3 times the BENEFIT AMOUNT
Coma	100%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	25%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson's Disease	25%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	25%	1 times the BENEFIT AMOUNT
Addison's Disease	10%	1 times the BENEFIT AMOUNT

DEFINITIONS

Active Employment means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.
Temporary and seasonal workers are excluded from coverage.

Addison's Disease means the diagnosis of a long-term endocrine disorder that occurs when your body produces insufficient amounts of steroid hormones produced by your adrenal glands, confirmed via blood tests, urine tests, or medical imaging.

Advanced Dementia means a clinically established diagnosis of Alzheimer's Disease, or other type of permanent and progressive advanced dementia, with severe cognitive decline and with findings consistent with a Global Deterioration Scale (GDS) or Functional Assessment Staging (FAST) Stage 3 or more, or a Clinical Dementia Rating Scale (CDR) of 1.

Amyotrophic Lateral Sclerosis (ALS) means the diagnosis of a motor neuron disease, marked by progressive muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

Benign Brain Tumor means the diagnosis of a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including, but not limited to:
- Loss of vision;
- Loss of hearing; or
- Balance disruption.

For purposes of the Policy, the following are not considered Benign Brain Tumors:
- Tumors of the skull;
- Pituitary adenomas; and
- Germinomas.

Benign Brain Tumor does not include diagnosis of any of the following conditions prior to your coverage effective date:
- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; and
- Turcot Syndrome.

Bone Marrow Transplant means the clinical diagnosis of the need for a surgical transplant when you have been added to the *Be The Match* registry for a bone marrow transplant.

Bone Marrow Transplant includes a clinical diagnosis and actual transplant that occurs before you are able to be added to the *Be The Match* registry.

Cancer means the diagnosis of a group of diseases characterized by the uncontrolled growth and/or spread of abnormal cells. Cancer is limited to malignancies of solid tissue, blood or lymph tissue and includes leukemia, lymphoma and Hodgkin's disease.

The diagnosis of Cancer must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This requires looking at the suspect tumor, tissue or specimen at the microscopic level such that malignancy may be determined. A clinical diagnosis of Cancer will be accepted as evidence that Cancer exists when a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening.

For the purposes of the Policy, the following are not considered Cancer:
- Basal cell carcinoma and squamous cell carcinoma of the skin;
- Carcinoma In Situ;
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm;
- Pre-malignant conditions or polyps; and
- Any other histologically benign or nonmalignant condition.

Carcinoma in Situ (CIS) means the diagnosis of tumor cells tending toward malignancy but that do not invade the underlying tissue (i.e. malignant cells confined to the epithelium without penetration of the basement membrane). This diagnosis must be confirmed by a study of the suspect tissue in a pathologic specimen that meets the American Joint Committee on Cancer or the American Board of Pathology criteria.

For purposes of the Policy, the following are not considered Carcinoma In Situ:
- Basal cell carcinoma and squamous cell carcinoma of the skin;
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm; and
- Pre-malignant conditions or conditions with malignant potential.

Certificate means the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

Coma means the diagnosis of a continuous state of profound unconsciousness, characterized by having a Glasgow scale of 3; defined as the absence of:
- Eye opening;
- Verbal response; and
- Motor response.

The condition must require intubation for respiratory assistance and must not be medically induced.

"Continuous state of profound unconsciousness" means 14 consecutive days or longer.

Coronary Angioplasty means a diagnosis of significant coronary artery disease which is causing symptoms and for which a cardiologist advises a procedure, done through the blood vessels, to open a blocked coronary artery and/or remove a blood clot. This includes coronary balloon angioplasty, angiojet clot removal, and rotational and orbital atherectomy procedures.

Coronary Artery Bypass means the diagnosis of severe left main or multi-vessel coronary artery disease (such as a SYNTAX score ≥23) for which is advised an open heart coronary artery bypass surgery - a surgical procedure that requires an incision through the chest and an incision in the heart and/or attached blood vessels.

Critical Illness means any of the following as defined:

- Addison's Disease; or
- Advanced Dementia; or
- Amyotrophic Lateral Sclerosis (ALS); or
- Benign Brain Tumor; or
- Bone Marrow Transplant; or
- Cancer; or
- Carcinoma in Situ; or
- Coma; or
- Coronary Angioplasty; or
- Coronary Artery Bypass; or
- Heart Attack; or
- Loss of Hearing; or
- Loss of Sight; or
- Loss of Speech; or
- Major Organ Transplant; or
- Multiple Sclerosis; or
- Parkinson's Disease; or
- Permanent Paralysis; or
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke; or

Different Diagnosis means any of the following:

- A diagnosis of a Critical Illness that is for a different illness/condition than a previously diagnosed illness/condition. Note: A Cancer that has spread to a different area of the body is not a different illness/condition than the previously diagnosed Cancer.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs more than 12 months after the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs more than 12 months after the date of the previous diagnosis.

Exception: A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma, is not considered a Different Diagnosis regardless of the time period between diagnoses.

- A diagnosis of Skin Cancer is considered a Different Diagnosis from Cancer.
- A diagnosis of Carcinoma in Situ is considered a Different Diagnosis from Cancer.
- A diagnosis of Skin Cancer is considered a Different Diagnosis from Carcinoma in Situ.

Doctor means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and who is providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Employee means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Heart Attack means the diagnosis of a clinical picture of myocardial infarction that was caused by a blockage of one or more coronary arteries. The medical evidence must be consistent with the diagnosis of heart muscle death. Significant electrocardiogram (EKG) changes must be seen, and one or both of the following must confirm the acute myocardial infarction (Heart Attack):

- Cardiac enzyme changes as typically seen with myocardial damage found in the blood (elevated CK-MB isoenzyme fraction or elevated troponins)
- Confirmatory imaging test, such as a nuclear imaging test or echocardiogram that is consistent with a myocardial infarction.

A sudden cardiac arrest is not in itself considered a Heart Attack.

Hospital means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
- It is under the supervision of a medical staff and has one or more Doctors available at all times;
- It provides 24 hours a day service by registered graduate nurses (RNs); and
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Insured Person means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

Loss of Hearing means the diagnosis of profound deafness in both ears that is not correctable.

Loss of Sight means the diagnosis of clinically proven irreversible reduction of sight in both eyes with:

- Sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (metric acuity) or 20/200 (Snellen or E-Chart Acuity); or
- Visual field restriction to 20 degrees or less in both eyes.

Loss of Speech means the clinical diagnosis of total and permanent loss of the ability to speak.

Major Organ Transplant means the irreversible failure of your heart, lung, pancreas, entire kidney or liver, or any combination thereof, determined by a Physician specialized in care of the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If you receive the transplant prior to placement on the network, the network requirement will be waived.

Multiple Sclerosis means the unequivocal diagnosis of multiple sclerosis following more than one episode of well-defined neurological symptoms and signs and confirmed by a neurological exam and MRI scan of the brain or spinal fluid analysis. Symptoms must persist for 6 months to ensure that the condition is permanent.

Parkinson's Disease means the diagnosis of a chronic, progressive neurodegenerative disorder characterized by any combination of four cardinal signs: rest tremor; rigidity; bradykinesia; and gait disturbance.

Permanent Paralysis means the diagnosis of total and permanent loss of the use of two or more limbs (arms or legs or combination) due to accident or sickness for a continuous period of at least 60 days.

Permanent Paralysis does not include paralysis as the result of a Stroke.

Policy means the written group insurance contract between us and the Policyholder.

Policyholder means the Employer to which the Policy is issued and who sponsors the coverage for its Employees.

Same Diagnosis means either of the following:

- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs within 12 months of the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs within 12 months of the date of the previous diagnosis.

Exception: A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma, is considered the Same Diagnosis regardless of the time period between diagnoses.

Skin Cancer means the diagnosis of tumor cells tending toward malignancy and which invade the underlying tissue.

The Skin Cancer diagnosis must be confirmed by a study of the suspect tissue in a pathologic specimen that meets the American Joint Committee on Cancer or the American Board of Pathology criteria.

Skin Cancer includes:

- Basal cell carcinoma and squamous cell carcinoma of the skin; and
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm.

Stem Cell Transplant means the clinical diagnosis of a blood or bone marrow malignancy for which the need for a surgical stem cell transplant has been advised.

Stroke means the diagnosis of an acute cerebral event including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis of Stroke must be based on confirmatory neuroimaging studies and evidence of persistent neurological impairment confirmed at the time of discharge from a Hospital.

Stroke does not include:

- Transient ischemic attacks (TIA)
- Ischemic disorders of the vestibular system;
- Brain injury related to trauma or infection; or
- Brain injury associated with hypoxia/anoxia or hypotension.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period.

EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you apply for coverage on or before that date.
- The first day of the month following the date you apply for coverage.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

CHANGE OF INSURANCE CARRIERS

If you are not in Active Employment due to Injury or Sickness on the effective date of the Employer's coverage under our Policy, and you were covered under the Employer's prior group policy of critical illness or specified disease insurance at the time the Employer's coverage under our Policy became effective, we will provide continuity of coverage under our Policy. In order for this provision to apply, the prior policy's coverage must be similar to our Policy.

If you are not in Active Employment due to Injury or Sickness on the effective date of our Policy, and you would otherwise be eligible to become insured under our Policy, we will provide limited coverage under our Policy. Coverage under this provision will begin on our Policy effective date and will continue until the earliest of the following:

- The date you return to Active Employment.
- The end of any period of continuance or extension provided under the prior policy.
- The date coverage would otherwise end, according to the provisions of our Policy.

Your coverage under this provision is subject to payment of premiums.

Any benefits payable under this provision will be paid as if the prior policy had remained in force. We will reduce our payment by any amount for which the prior carrier is liable.

If your coverage ends under this provision, or if you were not covered under the Employer's prior policy on the date that policy terminated, the EFFECTIVE DATE OF COVERAGE provision under our Policy will apply.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your coverage.

- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the Policyholder's grace period, if the Policyholder does not remit premium to us by the end of such period.
- The last day you are in Active Employment.
- The date the total maximum benefit amount has been paid for all Critical Illnesses.

We will provide coverage for a payable claim that occurs while you are covered under the Policy.

POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:
- There is less than 15% participation of those eligible persons who pay all or part of their premium for the Policy.
- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

We reserve the right to review and terminate all class(es) covered under the Policy if any class(es) cease(s) to be covered.

If the Policyholder fails to pay the full premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least 60 days prior to the termination date.

The Policyholder may terminate the Policy by written notice delivered to us at our home office prior to the termination date. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, the termination will not affect a payable claim.

PORTABILITY

Portability means you have the option to continue your coverage after it would otherwise terminate if certain conditions are met. You must elect portability before you reach age 70.

To continue your coverage, you must apply for portability and pay the first premium within 31 days of the date your coverage would otherwise terminate due to any of the following:
- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Insured Persons.
- The Policyholder terminates coverage under the Policy for all Insured Persons, and does not replace it with a similar insurance plan.
- You are no longer eligible for coverage under the Policy.

You can decrease, but not increase, the ported coverage amount. Ported coverage is subject to all the terms of the Policy and this Certificate.

Premiums will be billed directly to you. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time you apply for portability. We may change the portability premium rates at any time upon 60 days written notice to you.

Coverage continued under this provision will end on the earliest of the following:
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The date you die.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

GRACE PERIOD

The Policyholder has a grace period of 60 days for the payment of any premium due except the first. During the grace period the Policy will remain in force. If full payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance written notice of termination, or if we have given the Policyholder advance written notice of termination as described under the POLICY TERMINATION provision.

If you are on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force. If full payment is not received by us by the end of the grace period, your coverage will automatically terminate at the end of the grace period. A pro rata premium payment is required for any period your coverage was in force during the grace period.

REPRESENTATIONS NOT WARRANTIES

We consider any statements the Policyholder and you make in an application or enrollment form to be representations and not warranties. No statements made by you will be used to reduce or deny any claim or to cancel your coverage unless both of the following are true:
- The statement is in writing and is signed by you.
- A copy of that statement is given to you or your personal representative.

INCONTESTABILITY

Except in the case of fraud, no statement made by you in an application or enrollment form relating to your insurability will be used to contest the insurance for which the statement was made after the coverage has been in force for two years during your lifetime.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:
- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:
- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

MISSTATEMENT OF AGE OR TOBACCO USE STATUS

If premiums are based on your age or tobacco use status and you have misstated your age, or tobacco use status, we will make a fair adjustment of benefits to reflect the amount that the premium paid would have purchased at your true age or based upon your tobacco use status. We may require satisfactory proof of your age before paying any claim.

ASSIGNMENT
No assignment of benefits under the Policy is valid unless otherwise specified in the Policy.

AGENCY
For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

CONFORMITY WITH STATE STATUTES
Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the jurisdiction where the Policy is issued is automatically amended to conform to the minimum requirements of such law.

CHANGES TO POLICY OR CERTIFICATE
No agent, representative or employee of ours or of any other entity may change or waive the terms of the Policy, or of any Certificate or rider issued under it, except in writing signed by one of our executive officers and endorsed or attached to the Policy.

If there is a conflict between the terms of this Certificate or any attached rider and the Policy, the Policy controls.

CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on the SCHEDULE OF BENEFITS if you are diagnosed with a Critical Illness after your coverage effective date. The percentage of BENEFIT AMOUNT payable is listed for the Critical Illness on the SCHEDULE OF BENEFITS.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of this certificate. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on the SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable to you for each Critical Illness in the Certificate during your lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness.

When the total maximum benefit amount has been paid for a Critical Illness, no further benefits are payable for that Critical Illness. When the total maximum benefit amount has been paid for all Critical Illnesses, no further benefits are payable and your coverage (including all riders) terminates.

BASE MODULE

Benefits for Heart Attack, Cancer, Stroke, Major Organ Transplant, Coronary Artery Bypass and Carcinoma in Situ (CIS) are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Heart Attack or Coronary Artery Bypass must be made by a cardiologist or a Doctor familiar with the specific condition. A diagnosis of Stroke must be made by a neurologist or a Doctor familiar with the diagnosis of Stroke.

If you are on the UNOS (United Network for Organ Sharing) list for a combined transplant, only one Major Organ Transplant benefit will be payable for the diagnosis.

MAJOR ORGAN MODULE

Benefits for, Coronary Angioplasty, are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Coronary Angioplasty, must be made by a cardiologist or a Doctor familiar with the diagnosis of the specific condition.

QUALITY OF LIFE MODULE

A Critical Illness under this module, other than Coma, is not eligible for multiple benefit payments.

Benefits for Permanent Paralysis, Loss of Sight, Loss of Hearing, Loss of Speech, Coma, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Advanced Dementia, including Alzheimer's Disease and Addison's Disease are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Loss of Sight must be certified by an ophthalmologist or a Doctor familiar with the diagnosis of Loss of Sight.

A diagnosis of Loss of Hearing must be made by an otolaryngologist or a Doctor familiar with the diagnosis of Loss of Hearing.

A diagnosis of Advanced Dementia must be made by a board certified or board eligible neurologist or a Doctor familiar with the diagnosis of Advanced Dementia.

A diagnosis of Multiple Sclerosis must be made by a neurologist or a Doctor familiar with the diagnosis of the specific condition. Genetic testing does not qualify as a diagnosis.

Benefits for Parkinson's Disease are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage) or you become incapacitated, meaning:

- Exhibiting 2 or more of the following clinical manifestations:
  - Muscle rigidity;
  - Tremor; and
  - Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses); **and**
- Resulting in the inability to perform independently 2 or more of the following activities of daily living:
  - Eating;
  - Bathing;
  - Dressing;
  - Toileting;
  - Transferring; and
  - Maintaining continence.

A diagnosis of Parkinson's Disease must be made by a psychiatrist or neurologist or a Doctor trained in the diagnosis of Parkinson's Disease.

ENHANCED CANCER MODULE

Benefits for Benign Brain Tumor, Skin Cancer, Bone Marrow Transplant and Stem Cell Transplant are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

CLAIMS

NOTICE OF CLAIM
Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM
The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM
The claim form(s) may require completion by you and the Employer and your attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM
You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION
We may require you to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS
Benefits are payable to you unless otherwise specified. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children, in equal shares.
3. Your grandchildren, in equal shares.
4. Your parents, in equal shares.
5. Your siblings, in equal shares.
6. Your estate.

If a survivor entitled to receive a payment dies before receiving it, we will make payment to that person’s estate.

“Spouse” in this provision means your lawful spouse.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

SPOUSE CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CCI2

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

SPOUSE BENEFIT AMOUNT

Choice of $2,500 or $5,000 or $7,500
or $10,000 or $12,500 or $15,000

SPOUSE CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	2 times the BENEFIT AMOUNT
Major Organ Transplant	100%	2 times the BENEFIT AMOUNT
Coronary Artery Bypass	25%	2 times the BENEFIT AMOUNT
Carcinoma in Situ (CIS)	25%	2 times the BENEFIT AMOUNT

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Coronary Angioplasty	10%	2 times the BENEFIT AMOUNT

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	2 times the BENEFIT AMOUNT
Skin Cancer	10%	2 times the BENEFIT AMOUNT
Bone Marrow Transplant	25%	2 times the BENEFIT AMOUNT
Stem Cell Transplant	25%	2 times the BENEFIT AMOUNT

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight, Hearing or Speech	100%	3 times the BENEFIT AMOUNT
Coma	100%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	25%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson's Disease	25%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	25%	1 times the BENEFIT AMOUNT
Addison's Disease	10%	1 times the BENEFIT AMOUNT

SPOUSE CRITICAL ILLNESS BENEFITS

The benefit percentages for your Spouse are the same as the benefit percentages for you as shown in the SCHEDULE OF BENEFITS section of the Certificate.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

Spouse means your lawful spouse.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

EFFECTIVE DATE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you apply for Spouse coverage on or before that date.

- The first day of the month following the date you apply for Spouse coverage.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.
- The date your Spouse's total maximum benefit amount has been paid for all Critical Illnesses.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse can apply to continue Spouse coverage if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, your Spouse must be under age 70 and your Spouse must apply for portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse is approved by us for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under this rider. Your Spouse can decrease, but not increase, the ported coverage amount. Ported coverage is subject to all the terms of the Policy and Certificate.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Spouse is diagnosed with a Critical Illness after your Spouse's coverage effective date. The percentage of BENEFIT AMOUNT payable is listed for the Critical Illness on this rider's SCHEDULE OF BENEFITS.

The benefits for your Spouse are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of the Certificate. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable for each Critical Illness in this rider during your Spouse's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness.

When the total maximum benefit amount for your Spouse has been paid for a Critical Illness, no further benefits are payable for that Critical Illness. When the total maximum benefit amount has been paid for all Critical Illnesses, no further benefits are payable and this rider terminates.

Payment of any benefits for your Spouse's Critical Illness will not impact the available BENEFIT AMOUNT for your Critical Illness coverage. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Spouse's Critical Illness coverage as long as your coverage remains in force.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Spouse's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Spouse to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

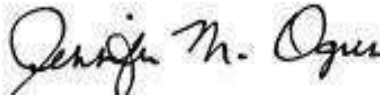
Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Spouse's coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

CHILDREN'S CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CCI2

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

CHILDREN'S BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	2 times the BENEFIT AMOUNT
Cancer	100%	2 times the BENEFIT AMOUNT
Stroke	100%	2 times the BENEFIT AMOUNT
Major Organ Transplant	100%	2 times the BENEFIT AMOUNT
Coronary Artery Bypass	25%	2 times the BENEFIT AMOUNT
Carcinoma in Situ (CIS)	25%	2 times the BENEFIT AMOUNT

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Coronary Angioplasty	10%	2 times the BENEFIT AMOUNT

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	2 times the BENEFIT AMOUNT
Skin Cancer	10%	2 times the BENEFIT AMOUNT
Bone Marrow Transplant	25%	2 times the BENEFIT AMOUNT
Stem Cell Transplant	25%	2 times the BENEFIT AMOUNT

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight, Hearing or Speech	100%	3 times the BENEFIT AMOUNT
Coma	100%	2 times the BENEFIT AMOUNT
Multiple Sclerosis	25%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson's Disease	25%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	25%	1 times the BENEFIT AMOUNT
Addison's Disease	10%	1 times the BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

The benefit percentages for your Children are the same as the benefit percentages for you as shown in the SCHEDULE OF BENEFITS section of the Certificate. Benefit percentages for the Additional Child Diseases are shown below.

Additional Child Diseases module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Cerebral Palsy	100%	1 times the BENEFIT AMOUNT
Congenital Birth Defects	100%	1 times the BENEFIT AMOUNT
Cystic Fibrosis	100%	1 times the BENEFIT AMOUNT
Down Syndrome	100%	1 times the BENEFIT AMOUNT
Gaucher Disease, Type II or III	100%	1 times the BENEFIT AMOUNT
Infantile Tay Sachs	100%	1 times the BENEFIT AMOUNT
Niemann-Pick Disease	100%	1 times the BENEFIT AMOUNT
Pompe Disease	100%	1 times the BENEFIT AMOUNT
Type IV Glycogen Storage Disease	100%	1 times the BENEFIT AMOUNT

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

Additional Child Diseases means in addition to the benefits provided for Critical Illnesses as defined in the Certificate, this rider also covers the following child diseases:

- Cerebral Palsy.
- Congenital Birth Defects.
- Cystic Fibrosis.
- Down Syndrome.
- Gaucher Disease, Type II or III.
- Infantile Tay Sachs.
- Niemann-Pick Disease.
- Pompe Disease.
- Type IV Glycogen Storage Disease.

This definition does not include premature birth or stillbirth caused or contributed to by a Critical Illness or Additional Child Disease.

Cerebral Palsy means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of Cerebral Palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder.

Child or **Children** means a child from birth but less than 26 years of age who is one of the following:

- Your natural or adopted child from the date of placement or order granting custody.
- Your stepchild.
- A child for whom you are a legal guardian.
- Your foster child.

The child must also meet all of the following conditions:

- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing.

Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

Congenital Birth Defects means the malformation of an organ or organ system that results in the recommendation of surgery.

Examples include but are not limited to the following:
- Heart defects.
- Lung defects.
- Spina Bifida.
- Cleft lip or palate.
- Limb malformations.

Congenital Birth Defects includes developmental disorders of the brain or being born blind without the recommendation of surgery.

Congenital Birth Defects does not include prematurity.

Critical Illness has the same meaning as in the Certificate. This definition does not include premature birth or stillbirth caused or contributed to by a Critical Illness or Additional Child Disease.

Cystic Fibrosis means a definite diagnosis of cystic fibrosis by a licensed family practitioner, pediatrician or pulmonologist where the Child has chronic lung disease and pancreatic insufficiency. The diagnosis made via a sweat test should be based upon sweat chloride concentrations greater than 60 mmol/L on two independent tests.

Down Syndrome means diagnosis of down syndrome through a study of the 21st chromosome.

Down Syndrome includes:
- Trisomy 21 - an individual has three instead of two #21 chromosomes.
- Translocation - an extra part of the 21st chromosome is attached to another chromosome.
- Mosaicism - the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

Gaucher Disease, Type II or III means a definitive diagnosis of Gaucher Disease, Type II or III through a blood test reviewing beta-glucosidase leukocyte (BGL).

Infantile Tay Sachs means a definitive diagnosis of Infantile Tay Sachs through a blood test reviewing Hexosaminidase A levels.

Niemann-Pick Disease means a definitive diagnosis of Niemann-Pick, Type A, B, or C, through blood test or genetic test.

Pompe Disease (Type II Glycogen Storage Disease) means a definitive diagnosis of Pompe Disease (Type II Glycogen Storage Disease) through enzyme testing or genetic testing.

Spouse means your lawful spouse.

Type IV Glycogen Storage Disease means a definitive diagnosis or Type IV Glycogen Storage Disease through testing of glycogen branching enzyme deficiency in the liver, muscle, or skin, or through genetic testing.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.

- Your Critical Illness coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If both you and your Spouse are covered under the Policy as an Employee, then only one of you may cover your Children under this rider. If the parent who is covering the Children stops being insured as an Employee then the other parent may apply for Children's coverage under this rider within 60 days.

EFFECTIVE DATE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the later of the following dates:

- The date your Employee coverage is effective.
- The date your Children are eligible for coverage.

Your eligible newborn Child is automatically covered for the first 30 days after birth. This includes an adopted newborn Child who is placed with you within 30 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then coverage for the newborn will be at the lowest level available. If you do not already have Children's coverage under this rider, then Child coverage beyond the 30th day is subject to the conditions regarding application and Active Employment and having no approved Employee claims under the Policy.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 30 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 30 days after birth, the "event" will be the date of placement. No additional premium is required.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Children's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The date the Child reaches age 26, unless he/she is disabled as defined under the definition of Child. Coverage of a disabled Child ends when there is no longer evidence satisfactory to us that the disability is continuing.
- The date your Child's total maximum benefit amount has been paid for all Critical Illnesses.

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date you no longer have any eligible Children covered under this rider. See the PORTABILITY FOLLOWING DEATH provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH

If you die and your Spouse is approved by us for portability under the Spouse Critical Illness Rider, then this rider can be continued under your Spouse's coverage. Following portability of this rider, Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date there are no longer any eligible Children covered under this rider.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

CRITICAL ILLNESS BENEFITS

The benefits for your Children are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate. Benefits for the Additional Child Diseases module are shown below.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis from any previously diagnosed Critical Illness or Additional Child Disease. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Critical Illness and Additional Child Disease. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable for each Critical Illness and Additional Child Disease in this rider during your Child's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness or Additional Child Disease.

When the total maximum benefit amount for a Child has been paid for a Critical Illness or Additional Child Disease, no further benefits are payable for that Child for that Critical Illness or Additional Child Disease. When the total maximum benefit amount for a Child has been paid for all Critical Illnesses and Additional Child Diseases, no further benefits are payable for that Child. When the total maximum benefit has been paid for all Children for all Critical Illnesses and Additional Child Diseases, no further benefits are payable and this rider terminates.

Payment of any benefits for your Child's Critical Illness or Additional Child Disease will not impact the available BENEFIT AMOUNT for your Critical Illness. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Child's Critical Illness or Additional Child Disease as long as your coverage remains in force.

A diagnosis of any Critical Illness or Additional Child Disease must be made after your Child's live birth and by a Doctor familiar with the diagnosis of the specific condition.

ADDITIONAL CHILD DISEASES MODULE

Benefits for Cerebral Palsy, Congenital Birth Defects, Cystic Fibrosis, Down Syndrome, Gaucher Disease, Type II or III, Infantile Tay Sachs, Niemann-Pick Disease, Pompe Disease and Type IV Glycogen Storage Disease are payable when we receive due proof of such condition which is diagnosed after your Child's coverage effective date (including the effective date of any changes to coverage).

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Child's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Child to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, benefits will be paid to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

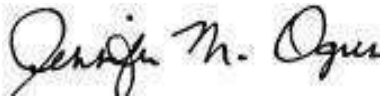
Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CCI2

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

DEFINITIONS

Covered Person means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse who is covered under your Spouse Critical Illness Rider.
- Your Children who are covered under your Children's Critical Illness Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Critical Illness coverage effective date.

EFFECTIVE DATE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

CHANGE OF INSURANCE CARRIERS

The CHANGE OF INSURANCE CARRIERS provision in the Certificate is revised to include an Employee whose coverage was being continued under a similar continuation provision in the Employer's prior group policy of critical illness or specified disease insurance at the time the Employer's coverage under our Policy became effective.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Critical Illness insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence,

then insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during an FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

Sickness or Injury

If you are on a Leave of Absence due to your sickness or injury, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 9 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

Military Leave

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) and applicable state law, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 3 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy due to Active Employment.
- The date of your death.
- The date you become covered under another group critical illness or specified disease insurance policy as an employee or member.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, insurance under the Policy will stay in force only if all of the following conditions are met:

- Critical Illness insurance is in force for Employees under the Policy; and
- You are in an eligible class for coverage under the Policy; and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

RETURN TO ACTIVE EMPLOYMENT

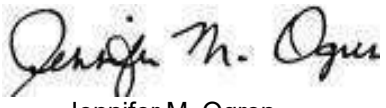
If coverage is not continued during an FMLA or State FML Leave of Absence, and you return to Active Employment immediately following the end of the FMLA or State FML Leave of Absence and while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated effective the date you return to Active Employment. The amount(s) of coverage will be subject to the SCHEDULE OF BENEFITS in effect on the date you return to Active Employment. We will not apply a new Eligibility Waiting Period for the same or lesser amount(s) of coverage.

If coverage is not continued during your Leave of Absence for active military service, and you return to Active Employment while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated in accordance with USERRA and applicable state law.

If coverage is not continued during any other period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Employees under the Policy, then the terms of the Certificate and riders will apply.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

WELLNESS BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CCI2

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

WELLNESS BENEFIT

You:	$75
Your Spouse:	$75
Your Children:	50% of your wellness benefit amount, to a maximum of $150 for all Children in one calendar year

DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

Covered Person means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse who is covered under your Spouse Critical Illness Rider.
- Your Children who are covered under your Children's Critical Illness Rider.

GENERAL PROVISIONS

ELIGIBILITY
If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:
- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

EFFECTIVE DATE
Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION
This rider will terminate on the earliest of the following:
- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.

PORTABILITY
If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE
If you die or divorce and your Spouse is approved by us for portability under the Spouse Critical Illness Rider, then this rider can also be continued under your Spouse's coverage.

ASSIGNMENT
At the time of claim under this rider, you can assign the payment of a benefit under this rider to a third party who is not the Policyholder.

BENEFITS

We will pay you a wellness benefit (shown on the SCHEDULE OF BENEFITS) if a Covered Person has a health screening test.

A wellness benefit is limited to one annual payment per Policy year per Covered Person.

Health screening tests include, but are not limited to:

- Blood test for triglycerides
- Pap smear or thin prep pap test;
- Flexible sigmoidoscopy
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography

- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- PSA (prostate cancer)
- Electrocardiogram (EKG)
- Routine eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through 18
- Biometric screenings

CLAIMS

The PHYSICAL EXAMINATION provision does not apply to this rider.

NOTICE OF CLAIM

Written notice of your claim must be given to us during the same Policy year the health screening test occurs or within 30 days of the end of the Policy year, whichever is later. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of the health screening test. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

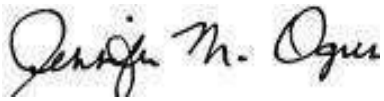
Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

Carolyn M. Johnson
President



Jennifer M. Ogren
Secretary

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 122
Minneapolis, Minnesota 55440-0122

Plan Name, Number and Name and Address of Plan Sponsor:
Forest River, Inc. Welfare Benefit Plan
71143-8CCI2
Forest River, Inc.
900 County Road 1
Elkhart, IN 46515

Name, Address, and Telephone Number of the Plan Administrator:
David Besinger, HR Manager/In-House Counsel
900 County Road 1
Elkhart, IN 46515
574-389-4600

Identification Numbers
IRS Employer Identification Number: 20-3284366
Plan Number: 510

Agent for Legal Process: Plan Administrator

Trustees: None

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Premiums are 100% Employee paid.

Plan Year: January 1 through December 31

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, 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.

YOUR HOSPITAL CONFINEMENT INDEMNITY INSURANCE PLAN

For Employees of
Forest River, Inc.

GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 877-236-7564

POLICYHOLDER:	Forest River, Inc.
GROUP POLICY NUMBER:	71143-8CHI2
POLICY EFFECTIVE DATE:	October 1, 2021
GOVERNING JURISDICTION:	Indiana

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

Benefits are paid for Hospital Confinements and other covered losses as defined in the Certificate. The Policy does not constitute comprehensive health insurance coverage (often referred to as "major medical insurance coverage"). In addition, the Policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid under the Policy for Hospital Confinement or other covered losses as indemnity insurance and are not intended to cover medical expenses.

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate replaces any other Certificates we may have given you for the same level of coverage under the Policy.

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address. The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

Exclusions may apply.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.

William Bainbridge
President

Melissa A. O'Donnell
Secretary

TABLE OF CONTENTS

Arizona residents:
Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

California residents:
If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution and any policy or membership fee paid refunded, by returning the Certificate to the Policyholder by mail or other delivery method for cancellation without claim.

Florida residents:
The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.

Idaho residents:
If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 10 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.

New Mexico residents:
If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 30 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.

West Virginia residents:
Please read this Certificate carefully. If you are not satisfied with it for any reason, you may return it within 10 days after receipt for a refund of any premium you paid.

SCHEDULE OF BENEFITS

EMPLOYER: Forest River, Inc.
GROUP POLICY NUMBER: 71143-8CHI2

ELIGIBLE CLASS(ES)
All Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.
Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT
Employees: 30 hours per week

ELIGIBILITY WAITING PERIOD
Persons in an eligible class on or before the Policy effective date: End of month in which you complete a continuous period of 60 days of Active Employment.

Persons entering an eligible class after the Policy effective date: End of month in which you complete a continuous period of 60 days of Active Employment.

CREDIT FOR PRIOR SERVICE
We will apply any prior period of work with the Employer toward the Eligibility Waiting Period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE
You pay the cost of your coverage.

BENEFIT AMOUNTS

DAILY CONFINEMENT AMOUNT(S)

Low	High
$100	$200

CONFINEMENT DAILY BENEFITS

Facility Confinement Benefits

Hospital Confinement	1 times the daily Confinement amount per day, up to a maximum of 30 days per Confinement
Critical Care Unit (CCU) Confinement	2 times the daily Confinement amount per day, up to a maximum of 15 days per Confinement
Rehabilitation Facility Confinement	1/2 of the daily Confinement amount per day, up to a maximum of 30 days per Confinement

Admission Benefits

Hospital Admission	$1,000 for the first day of Hospital Confinement, once per Confinement	$2,000 for the first day of Hospital Confinement, once per Confinement

Critical Care Unit (CCU) Admission	$2,000 for the first day of CCU Confinement, once per Confinement	$4,000 for the first day of CCU Confinement, once per Confinement

Only one type of facility Confinement or admission benefit is payable per day. Each type of admission benefit is payable 8 times per calendar year.

Any combination of facility Confinement and admission benefits payable will not exceed a total of 90 days during a period of Confinement.

OBSERVATION UNIT DAILY BENEFIT

Observation unit benefit	$500 per day, up to a maximum of 2 days per calendar year.

An observation unit benefit is not payable for any day that a facility Confinement or admission benefit is payable.

DEFINITIONS

Accident or **Accidental** means an unforeseen event that results in a bodily Injury.

Active Employment means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.
Temporary and seasonal workers are excluded from coverage.

Certificate means the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

Confined or **Confinement** means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or Critical Care Unit (CCU) or Rehabilitation Facility. There must be a charge for room and board, other than in any government, military or veterans' facility for which there is no charge for room and board.

Critical Care Unit means a specifically designated part of a Hospital commonly referred to as an intensive care unit which meets all of the following requirements:
- It provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care.
- It is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- It is permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- It is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis.
- It is assigned a Doctor on a full-time basis.

Critical Care Unit does not include a sub-acute intensive care unit that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward such as a step-down unit.

Doctor means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Employee means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Hospital means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located.
- It is under the supervision of a medical staff and has one or more Doctors available at all times.
- It provides 24 hours a day service by registered graduate nurses (RNs).
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or care for the aged, or care or treatment for persons suffering from mental diseases or disorders, or drug or alcohol addiction.

Injury means a bodily Injury that is the direct result of an Accident and not related to any other cause. Injuries must be independent of Sickness, disease, bodily infirmity and other causes.

Insured Person means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

Policy means the written group insurance contract between us and the Policyholder.

Policyholder means the Employer to which the Policy is issued and who sponsors the coverage for its Employees.

Rehabilitation Facility means a free-standing facility which meets the definition of Hospital but is specifically designated to provide coordinated multidisciplinary physical restorative services to inpatients including the treatment of mental diseases or disorders, or drug or alcohol addiction. Services must be provided under the direction of a Doctor knowledgeable and experienced in the type of rehabilitative medicine being provided.

Rehabilitation Facility includes a unit of a Hospital with beds set up and staffed and specifically designated for rehabilitative medicine.

Sickness means illness, infection, disease or any other abnormal physical condition that is not due to an Injury. Sickness includes pregnancy, infection and any other abnormal physical condition that is not caused by an Accident.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period.

EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you apply for coverage on or before that date.
- The first day of the month following the date you apply for coverage.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to Injury or Sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your coverage.
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the Policyholder's grace period, if the Policyholder does not remit premium to us by the end of such period.
- The last day you are in Active Employment.

We will provide coverage for a payable claim that occurs while you are covered under the Policy.

POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:

- There is less than 15% participation of those eligible persons who pay all or part of their premium for the Policy.
- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

We reserve the right to review and terminate all class(es) covered under the Policy if any class(es) cease(s) to be covered.

If the Policyholder fails to pay the full premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least 60 days prior to the termination date.

The Policyholder may terminate the Policy by written notice delivered to us at our home office prior to the termination date. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, the termination will not affect a payable claim.

PORTABILITY

Portability means you have the option to continue your coverage after it would otherwise terminate, if certain conditions are met. You must elect portability before you reach age 70.

To continue your coverage, you must apply for portability and pay the first premium within 31 days of the date your coverage would otherwise terminate due to any of the following:

- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Insured Persons.
- The Policyholder terminates coverage under the Policy for all Insured Persons, and does not replace it with a similar insurance plan.
- You are no longer eligible for coverage under the Policy.

You can decrease but not increase the ported coverage amount. Ported coverage is subject to all the terms of the Policy and this Certificate.

Premiums will be billed directly to you. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time you apply for portability. We may change the portability premium rates at any time upon 60 days written notice to you.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The date you die.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

GRACE PERIOD

The Policyholder has a grace period of 60 days for the payment of any premium due except the first. During the grace period the Policy will remain in force. If full payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance written notice of termination, or if we have given the Policyholder advance written notice of termination as described under the POLICY TERMINATION provision.

If you are on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force. If full payment is not received by us by the end of the grace period, your coverage will automatically terminate at the end of the grace period. A pro rata premium payment is required for any period your coverage was in force during the grace period.

REPRESENTATIONS NOT WARRANTIES

We consider any statements the Policyholder and you make in an application to be representations and not warranties. No statements made by you will be used to reduce or deny any claim or to cancel your coverage unless both of the following are true:

- The statement is in writing and is signed by you.
- A copy of that statement is given to you or your personal representative.

INCONTESTABILITY

The validity of the Policy will not be contested, except for nonpayment of premiums, after the Policy has been in force for two years after its date of issue. No statement made by you in an application or enrollment form relating to your insurability will be used to contest the insurance for which the statement was made after the coverage has been in force for two years during your lifetime.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

MISSTATEMENT OF AGE

If premiums are based on your age and you have misstated your age, we will make a fair adjustment of benefits to reflect the amount that the premium paid would have purchased at your true age. We may require satisfactory proof of your age before paying any claim.

ASSIGNMENT

No assignment of benefits under the Policy is valid, unless otherwise specified in the Policy.

AGENCY

For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

CONSUMER NOTICE

Questions regarding your policy or coverage should be directed to:

ReliaStar Life Insurance Company
877-236-7564
20 Washington Avenue South, Minneapolis, MN 55401

You may file a grievance with us either orally or in writing using the contact information above. We maintain a grievance procedure as required by Indiana law. You may contact us at any time to obtain information about this procedure and how to file a grievance.

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the jurisdiction where the Policy is issued, is automatically amended to conform to the minimum requirements of such law.

CHANGES TO POLICY OR CERTIFICATE

No agent, representative or employee of ours or of any other entity may change or waive the terms of the Policy, or of any Certificate or rider issued under it, except in writing signed by one of our executive officers and endorsed or attached to the Policy.

If there is a conflict between the terms of this Certificate or any attached rider and the Policy, the Policy controls.

BENEFITS

We will pay a benefit as shown on the SCHEDULE OF BENEFITS for an eligible Confinement or other covered loss that occurs on or after your coverage effective date, subject to the EXCLUSIONS of this Certificate.

CONFINEMENT DAILY BENEFITS

Only one type of facility Confinement benefit is payable per day. Confinement benefits are payable for each day you are Confined up to the maximums shown on the SCHEDULE OF BENEFITS.

Re-Confinements to a Hospital or Critical Care Unit (CCU) or Rehabilitation Facility that occur within 90 days after being discharged for the same or a related condition are considered to be part of the previous period of Confinement. A Confinement that begins more than 90 days after discharge for a previous period of Confinement is considered a new Confinement.

A Confinement benefit will not be payable for any day that an admission benefit is payable.

Admission: Only one type of admission benefit is payable per day. Admission benefits are payable upon admission to a Hospital or Critical Care Unit (CCU) or Rehabilitation Facility for Confinement as an inpatient due to treatment of an Injury or Sickness. The first day of Confinement must occur on or after your coverage effective date. The number of admission benefits payable during a period of Confinement are limited as shown on the SCHEDULE OF BENEFITS.

Hospital Confinement: Benefits are payable if you are Confined in a Hospital on an inpatient basis due to treatment of an Injury or Sickness.

Critical Care Unit (CCU) Confinement: Benefits are payable if you are Confined in a Critical Care Unit on an inpatient basis due to treatment of an Injury or Sickness. Once the CCU Confinement benefits have been paid for the maximum number of days in the SCHEDULE OF BENEFITS, any remaining days of Hospital Confinement during the same period of Confinement will be payable under the Hospital Confinement daily benefit, up to the maximum number of days in the SCHEDULE OF BENEFITS.

Rehabilitation Facility Confinement: Benefits are payable if you are Confined in a Rehabilitation Facility on an inpatient basis due to treatment of an Injury or Sickness.

OBSERVATION UNIT DAILY BENEFIT

Observation unit benefit: Benefits are payable if you are admitted to a Hospital observation unit for at least 4 consecutive hours other than as an inpatient. This benefit is not payable for any day that a facility Confinement or admission benefit is payable.

An observation unit is a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following outpatient surgery or following treatment in the Emergency Room by a Doctor, and that fully meets each of the following requirements:

- It is under the direct supervision of a Doctor or registered nurse.
- It is staffed by nurses assigned specifically to that unit.
- It provides care seven days per week, 24 hours per day.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal activity.
- Operation of a motorized vehicle while intoxicated. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Misuse of alcohol or taking of drugs, other than under the direction of a Doctor. **Exception:** This exclusion does not apply to a Confinement in an eligible Hospital or Rehabilitation Facility for the purpose of treatment for alcoholism or drug addiction.
- Elective surgery, except when required for appropriate care as determined by a Doctor as a result of your Injury or Sickness.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require you to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits are payable to you unless otherwise specified. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children, in equal shares.
3. Your grandchildren, in equal shares.
4. Your parents, in equal shares.
5. Your siblings, in equal shares.
6. Your estate.

If a survivor entitled to receive a payment dies before receiving it, we will make payment to that person’s estate.

If a survivor entitled to receive a payment has a special needs trust established, we will make payment to that person’s trust instead of to the person directly.

“Spouse” in this provision means your lawful spouse.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

SPOUSE HOSPITAL CONFINEMENT INDEMNITY RIDER

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CHI2

This rider is made a part of the Hospital Confinement Indemnity Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE
You pay the cost of coverage under this rider.

BENEFIT AMOUNTS
The benefit amounts for your Spouse are 100% of the Employee BENEFIT AMOUNTS as shown in the SCHEDULE OF BENEFITS section of the Certificate.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

Spouse means your lawful spouse.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Hospital Confinement Indemnity coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

EFFECTIVE DATE
Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you apply for Spouse coverage on or before that date.
- The first day of the month following the date you apply for Spouse coverage.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional coverage due to an increase in the Employee coverage amount will take effect on the same date as the Employee coverage increase.

Any decrease in coverage due to a decrease in the Employee coverage amount will take effect on the same date as the Employee coverage decrease, but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse can apply to continue Spouse coverage if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, your Spouse must be under age 70 and your Spouse must apply for portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse is approved by us for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under this rider. Your Spouse can decrease but not increase the ported coverage amount. Ported coverage is subject to all the terms of the Policy and Certificate.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

SPOUSE BENEFITS

The benefits for your Spouse are the same as your benefits as shown in the BENEFITS section of the Certificate, based on your Spouse's Confinement or other covered loss, and subject to the EXCLUSIONS of this rider.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal activity.
- An Accident while your Spouse is operating a motorized vehicle while intoxicated. Intoxication means your Spouse's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Misuse of alcohol or taking of drugs, other than under the direction of a Doctor. **Exception:** This exclusion does not apply to a Confinement in an eligible Hospital or Rehabilitation Facility for the purpose of treatment for alcoholism or drug addiction.
- Elective surgery, except when required for appropriate care as determined by a Doctor as a result of your Spouse's Injury or Sickness.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Spouse's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Spouse to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Spouse's coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

William Bainbridge
President

Melissa A. O'Donnell
Secretary

CHILDREN'S HOSPITAL CONFINEMENT INDEMNITY RIDER

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CHI2

This rider is made a part of the Hospital Confinement Indemnity Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE
You pay the cost of coverage under this rider.

BENEFIT AMOUNTS
The benefit amounts for your Children are 100% of the Employee BENEFIT AMOUNTS as shown in the SCHEDULE OF BENEFITS section of the Certificate. **Exception(s):** The benefit amount for your newborn Child is described under the NEWBORN BENEFIT provision below.

NEWBORN BENEFIT

Your newborn Child's Confinement, if you have coverage under this rider on the date of your newborn Child's birth	The same as benefits for any other Child.
Your newborn Child's Confinement, if you do <u>not</u> have coverage under this rider on the date of your newborn Child's birth	$200 No admission benefit is payable.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

Child or **Children** means a child from birth but less than 26 years of age who is one of the following:
- Your natural child.
- Your adopted child as of the earlier of the date of placement for the purpose of adoption or the date of entry of an order granting you custody of the child for purposes of adoption.
- Your stepchild.
- A child for whom you are a legal guardian.

- Your foster child.

The child must also meet all of the following conditions:
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing. Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

Spouse means your lawful spouse.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Hospital Confinement Indemnity coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If both you and your Spouse are covered under the Policy as an Employee, then only one of you may cover your Children under this rider. If the parent who is covering the Children stops being insured as an Employee then the other parent may apply for Children's coverage under this rider within 60 days.

EFFECTIVE DATE
Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:
- The date your Children are eligible for coverage, if you apply for Children's coverage on or before that date.
- The first day of the month following the date you apply for Children's coverage.
- The first day of the month following the date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical Leave of Absence and paid time off for nonmedical-related absences.

If you have Employee coverage but you do not have Children's coverage under this rider, and you acquire a new eligible Child due to birth, your eligible newborn Child is automatically covered under the terms of this rider for the NEWBORN BENEFIT as shown on the SCHEDULE OF BENEFITS. This includes an adopted newborn Child who is placed with you within 30 days after birth. The effective date of any coverage you apply for after birth is subject to the conditions above including Active Employment.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 30 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 30 days after birth, the "event" will be the date of placement. No additional premium is required.

EFFECTIVE DATE OF CHANGES TO COVERAGE
Once your Children's coverage begins, any increased or additional coverage due to an increase in the Employee coverage amount will take effect on the same date as the Employee coverage increase.

Any decrease in coverage due to a decrease in the Employee coverage amount will take effect on the same date as the Employee coverage decrease, but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The date the Child is no longer an eligible Child as defined by this rider. Eligibility of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date you no longer have any eligible Children covered under this rider. See the PORTABILITY FOLLOWING DEATH provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH

If you die and your Spouse is approved by us for portability under the Spouse Hospital Confinement Indemnity Rider, then this rider can be continued under your Spouse's coverage. Following portability of this rider, Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date there are no longer any eligible Children covered under this rider.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

CHILDREN BENEFITS

Benefits are payable for each covered Child. The benefits for your Children are the same as your Employee benefits as shown in the BENEFITS section of the Certificate, based on your Child's Confinement or other covered loss.
Exception(s): Benefits for your newborn Child are described under the NEWBORN BENEFIT provisions on this rider.

NEWBORN BENEFIT

If you have coverage under this rider on the date of your newborn Child's birth, then the benefits for the newborn Child under this rider are the same as for any other Child.

If you have Employee coverage but you do not have coverage under this rider on the date of your newborn Child's birth, and your newborn Child is Confined due to birth, then this rider provides a one-time benefit for your newborn Child as shown on the SCHEDULE OF BENEFITS. All other benefits under this rider are subject to the conditions regarding application, effective date and Active Employment.

EXCLUSIONS

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal activity.
- An Accident while your Child is operating a motorized vehicle while intoxicated. Intoxication means your Child's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Misuse of alcohol or taking of drugs, other than under the direction of a Doctor. **Exception:** This exclusion does not apply to a Confinement in an eligible Hospital or Rehabilitation Facility for the purpose of treatment for alcoholism or drug addiction.
- Elective surgery, except when required for appropriate care as determined by a Doctor as a result of your Child's Injury or Sickness.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Child's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Child to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

William Bainbridge
President

Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CHI2

This rider is made a part of the Hospital Confinement Indemnity Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

DEFINITIONS

Covered Person means:
- You, if you are covered for Hospital Confinement Indemnity insurance under the Policy.
- Your Spouse who is covered under your Spouse Hospital Confinement Indemnity Rider.
- Your Children who are covered under your Children's Hospital Confinement Indemnity Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Hospital Confinement Indemnity coverage effective date.

EFFECTIVE DATE
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION
This rider terminates on the earliest of the following:
- The date your Hospital Confinement Indemnity insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence

then insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or any applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during an FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

Sickness or Injury

If you are on a Leave of Absence due to your sickness or injury, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows 9 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

Military Leave

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) and any applicable state law, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows 3 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy due to Active Employment.

- The date of your death.
- The date you become covered under another group hospital confinement indemnity insurance policy as an employee or member.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, insurance under the Policy will stay in force only if all of the following conditions are met:
- Hospital Confinement Indemnity insurance is in force for Employees under the Policy; and
- You are in an eligible class for coverage under the Policy; and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during any period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Employees under the Policy, then the terms of the Certificate and riders will apply.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

William Bainbridge
President

Melissa A. O'Donnell
Secretary

WELLNESS BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: Forest River, Inc.

GROUP POLICY NUMBER: 71143-8CHI2

This rider is made a part of the Hospital Confinement Indemnity Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

CONTENTS

SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE
The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

WELLNESS BENEFIT

You:	$50 per day
Your Spouse:	$50 per day
Your Children:	50% of your wellness benefit amount, per day, per Child

The wellness benefit is payable up to a maximum of one day per Covered Person per calendar year. There is a maximum of $100 in wellness benefits payable for all Children per calendar year.

DEFINITIONS
General terms are defined in the DEFINITIONS section of the Certificate and riders.

Covered Person means:
- You, if you are covered for Hospital Confinement indemnity insurance under the Policy.
- Your Spouse who is covered under your Spouse Hospital Confinement Indemnity Rider.
- Your Children who are covered under your Children's Hospital Confinement Indemnity Rider.

GENERAL PROVISIONS

ELIGIBILITY
If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Hospital Confinement indemnity coverage effective date.

Your Spouse is eligible for coverage under this rider on the later of the date above or the date your Spouse is eligible for coverage under the Spouse Hospital Confinement Indemnity Rider.

Your Children are eligible for coverage under this rider on the later of the date above or the date each Child is eligible for coverage under the Children's Hospital Confinement Indemnity Rider.

EFFECTIVE DATE
Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION
This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Hospital Confinement Indemnity Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Hospital Confinement Indemnity Rider terminates.

PORTABILITY
If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE
If you die or divorce and your Spouse is approved by us for portability under the Spouse Hospital Confinement Indemnity Rider, then this rider can also be continued under your Spouse's coverage.

BENEFITS
We will pay you a wellness benefit for each day that a Covered Person has one or more eligible health screening tests, on or after the Covered Person's coverage effective date. This benefit is payable up to a maximum of one day per Covered Person per calendar year. The amounts are shown on the SCHEDULE OF BENEFITS.

Eligible health screening tests include, but are not limited to:

– Blood test for triglycerides
– Pap smear or thin prep pap test
– Flexible sigmoidoscopy
– CEA (blood test for colon cancer)
– Bone marrow testing
– Serum cholesterol test for HDL & LDL levels
– Hemoccult stool analysis
– Serum Protein Electrophoresis (myeloma)
– Stress test on bicycle or treadmill
– Fasting blood glucose test
– Thermography
– PSA (prostate cancer)
– Biometric screenings
– Electrocardiogram (EKG)
– Routine eye exam
– Routine dental exam

– Breast ultrasound, sonogram, MRI
– Chest x-ray
– Mammography
– Colonoscopy
– CA 15-3 (breast cancer)
– Well child/preventive exams for ages 1 through 18

EXCLUSIONS

The EXCLUSIONS section of the Certificate and riders does not apply to this rider.

CLAIMS

The PHYSICAL EXAMINATION provision does not apply to this rider.

NOTICE OF CLAIM

Written notice of your claim must be given to us during the same Policy year the health screening test occurs or within 30 days of the end of the Policy year, whichever is later. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of the health screening test. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

William Bainbridge
President

Melissa A. O'Donnell
Secretary

TRANSAMERICA
Employee Benefits

Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
Home Office: Cedar Rapids, Iowa
Adminstrative Office:
1400 Centerview Drive, P.O. Box 8063
Little Rock, Arkansas 72203-8063
Customer Service: (888) 763-7474

October 07, 2021

FOREST RIVER INC
ATTN: DAVID BESINGER
900 CR1 /PO BOX 3030
ELKHART, IN 46544

GROUP NUMBER: G000046683

Welcome to the Transamerica Life Insurance Company family.

Your Master Contract(s) is attached. Please take a moment to review the documents.

Should you have need for any administrative forms, you can find them on our website at www.TransamericaEmployeeBenefits.com.

Should you have any concerns or changes that may need to be made now or in the future, you may contact the following departments(s):

For Billing: 1-866-411-4159 or tebbillingservices@transamerica.com

For Claims or Customer Service: 1-888-763-7474 or tebcustresp@transamerica.com

We look forward to servicing your needs.

Sincerely,

Transamerica Life Insurance Company

TRANSAMERICA®

Revised April 29th, 2019

NOTICE OF PRIVACY PRACTICES TRANSAMERICA COMPANIES

This Notice is provided to you by the Transamerica companies listed at the end of this Notice. We value our customers and your trust in us, especially when you share your personal information with us. We understand that the privacy and security of that personal information is important to you. We call this information "data". This Notice describes the data we collect and how we use, share and protect such data. The types of data we collect and share depend on the type of product or service you have with us. Also, Transamerica websites' and applications' Terms of Use and Privacy Statements provide additional detail on the treatment and handling of data when interacting with these sites or applications. If your relationship with us ends, we will continue to handle your data in accordance with this Notice.

Data That We Collect: We collect the following types of data:

Data	Typical Data Sources
Name, email and physical address, age, social security and driver's license numbers, employment, financial and health data and history.	• You directly, when you submit applications and forms and engage in communications with us • Employers, healthcare providers, other insurance companies and other authorized entities
Data about your transactions with us. Data about your transactions with unaffiliated third parties ("Third Parties") that is shared with Transamerica. Transactional data collected as part of your interaction with Transamerica or provided by Third Parties can include , but is not limited to, account balances, accrued benefits, coverages, premiums, payment and claims history, financial transactions, and medical or health data.	• Our affiliates (companies under common ownership) • Third Parties • Transamerica's websites, digital platforms, and applications • Assistive technologies, mobile or wearable devices, or other similar technology
Credit history, employment information and other information about your creditworthiness, medical care and health.	• Consumer reporting agencies and other service providers we use such as third party data suppliers • Your employers, healthcare providers, other insurance companies and other authorized entities
Data about products and services you obtain or in which you might be interested.	• You • Third Parties with whom we have joint marketing arrangements • Other Third Parties as allowed
Data you provide to Third Parties when you have authorized the Third Party to share such data with other parties. This includes data collected through Third Party applications, websites, or other digital interfaces, data you share with us, data you have authorized us to receive, or data you have authorized Third Parties to share with us.	• Third Party applications, websites, or other digital interfaces where you have agreed to share your data • Assistive technologies, mobile or wearable devices, or other similar technology

How We Use Your Data: We use data to provide our services and for purposes allowed by law, this includes use authorized by you. For example, we may use your data to:

- Process claims and transactions,
- Research, develop,and market products and services,
- Prevent and prosecute fraud or criminal activities,
- Maintain your accounts,
- Comply with applicable laws and for security purposes,
- Maintain, operate, and market our business, or
- Support online customer experiences, digital platforms, and/or applications you elect to participate in

Sharing Data: We may share your data with Third Parties and affiliates as permitted or required by law, or when you authorize us to do so. In certain situations, our ability to share information is limited by other restrictions, such as certain contractual agreements with plan sponsors or similar arrangements. **We will honor those restrictions to the extent they conflict with the terms of this Notice**.

We may also share your data with Third Parties in certain circumstances, such as:

- Those who provide services to support our business, including processing claims, account maintenance, and marketing and sales,
- Credit bureaus,
- Insurance regulators, law enforcement, governmental authorities and other Third Parties in response to legal process or as required by law,
- Health care professionals, including to verify coverage or to provide information relating to a medical condition,
- Governmental agencies so they can decide if you are eligible for public benefits,
- Other financial companies in connection with joint marketing efforts,

- Other insurance companies (including successor insurers), agents and insurance support organizations to coordinate your benefits or in connection with insurance transactions involving you,
- Group policyholders, for example, regarding claims experience or to support service audits,
- Certificate or policyholders regarding the status of an insurance transaction,
- Those who have a legal or beneficial interest in your assets (such as creditors with a lien on your account),
- Your employer or plan sponsor as needed to support the administration of employee accounts (but only as permitted by law and only if you have established an account in connection with your employer),
- Your representatives and lawyers,
- To prevent and prosecute fraud or criminal activities,
- To conduct actuarial or research studies, and
- In connection with the sale or merger of all or part of our business

Our affiliates include a broad range of companies who provide financial services. These include insurance companies and agencies, and investment advisors. They also include agencies and broker/dealers who may not be included in the scope of this Notice. If we serve you through one of these professionals not covered under the Notice, you may contact them directly for information regarding their privacy practices. Specific contact information for these professionals can be found on your statements and other correspondence from them. We do not share information about your creditworthiness among our affiliates. The Transamerica affiliated companies with whom we may share your other information may include our companies with a Transamerica or Stonebridge name. For example, we may share your data with our affiliates:

- For their everyday business purposes;
- So they can tell you about products and services they offer;
- So they can determine which of their products and services may be of interest to you;
- So they can provide various services to us to support our business, such as claims processing, maintaining your account, and marketing products and services to you; or
- So they can audit themselves or their agents

Your Choice to Limit Marketing by Transamerica Affiliates: You may limit our affiliates' use of certain types of data to market their own products and services to you ("Opt Out"). To do this, choose one of the Opt Out methods set forth below. This data relates to your transactions and experiences with us. For example, this may include the products you own and your account history. Your choice to limit marketing offers from our affiliates will apply for at least 5 years from when you Opt Out. Once that period expires, we will send you a renewal Notice. That renewal Notice will allow you to continue to limit marketing offers from our affiliates for at least another 5 years. If you have already Opted Out of marketing offers from our affiliates, you do not need to Opt Out again until you receive a renewal Notice. If you hold a policy or account jointly with someone else, your Opt Out elections will apply to everyone on the account. When you are no longer our customer, we will continue to share your data as described in this Notice (including your Opt Out, if applicable). However, you may contact us at any time to elect to Opt Out.

To Opt Out: To limit our sharing of data with affiliates for marketing by affiliates as described above, you may:

- Call us at **877-257-4690** and our menu will prompt you through your choice(s), or
- Visit us online at **www.transamerica.com/optout**

Your Right of Access and Correction: You have a right of access and correction with respect to data we collect except data that relates to and is collected in connection with a claim or criminal or civil lawsuit involving you. You must make your request to us in writing listing the account or policy numbers with the data you are requesting to access. If you tell us of an error in the data, we will review it and if we agree, we will correct our records. If we don't agree, you may dispute our findings in writing and send your statement to us. We will include your statement whenever we provide your disputed information to anyone outside Transamerica. This is a summary of your rights. For a copy of our more detailed Notice of Insurance Information Practices as applicable to your product or service, please send a written request to 6400 C St. SW Cedar Rapids, IA 52499-0001.

Protecting Your Data: We maintain appropriate controls to limit access to data to persons who need access to it in order to do their jobs or to provide products and services to you. We train our workforce in the proper handling of data. In addition, we maintain other physical, technical, and administrative or procedural safeguards to protect your data.

Other Privacy Protections for Vermont Residents only. We will not share data we collect about you with Third Parties, except as permitted by Vermont law or authorized by you. We may still share data about our transactions or experiences with you with our affiliates. **For California Residents only.** If you are a California resident, you will receive a separate notice with additional choices.

We may revise this Notice. If we make material changes, we will notify you as required by law. This Notice is provided by the following Transamerica companies and any separate accounts established for products they offer:

Transamerica Advisors Life Insurance Company
Transamerica Capital, Inc
Transamerica Casualty Insurance Company
Transamerica Financial Life Insurance Company
Transamerica Investors Securities Corporation
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
Transamerica Retirement Advisors, LLC
Transamerica Retirement Solutions, LLC
Stonebridge Benefit Services, Inc

NOTICE OF PROTECTION PROVIDED BY THE
INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies. (For the purposes of this Notice, the terms "insurance company" and "insurer" mean and include health maintenance organizations ("HMOs")).

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis IN 46204
(317) 232-2385

The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

IMPORTANT NOTICE

Questions regarding your policy or coverage should be directed to:

Transamerica Life Insurance Company
Administrative Office: PO Box 869094, Plano, TX 75086-9817
Phone: 1-888-763-7474

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499
A Stock Company

Policyholder:	**FOREST RIVER INC**
Policy Number:	**T200075492**
Policy Effective Date:	**OCTOBER 1 2021**
Policy Anniversary Date:	**NOVEMBER 1**
Governing Jurisdiction:	**INDIANA**

Transamerica Life Insurance Company ("the Company," "we," "us," and "our") agrees to pay the benefits described in this Policy, subject to all terms, conditions, and limitations, in consideration of:
1. The Policyholder Application, a copy of which is attached to and made a part of this Policy; and
2. The payment of the first premium.

By our acceptance of the first premium paid by the Policyholder ("you," "your," and "yours") and by your receipt of this Policy, you agree:
1. To be bound by the terms of this Policy; and
2. To pay all premiums to us according to the terms of this Policy.

This Policy is subject to the laws of the governing jurisdiction in which it is issued. This is not a policy of workers' compensation insurance.

This Policy is signed for the Company at our Home Office to take effect on the Policy Effective Date.

General Counsel and Secretary

President

Master Policy for Group Term Life Insurance

20 Year Term Life Insurance
Renewable to Expiration Date
Premiums Subject to Change
Conversion to Permanent Life Insurance Option
Non-Participating – No Dividends

Administrative Office
PO Box 869094
Plano, TX 75086-9817
1-888-763-7474

Table of Contents

POLICY SCHEDULE

ELIGIBILITY REQUIREMENTS

Employee or Member – To become an Insured under this Policy:
1. Must be within the Age range of 16 through 65.
2. Must meet the eligibility requirements listed on the Policyholder's Application.
3. Must satisfactorily answer the Evidence of Insurability questions on the Application, if applicable.
4. Must be in Active Service.

Dependents (if available) **–** To become an Insured under this Policy:
1. Must meet the definition of a Dependent.
2. Must satisfactorily answer the Evidence of Insurability questions on the Application, if applicable.
3. Must not be eligible as an employee or member under this Policy.

EVIDENCE OF INSURABILITY

Evidence of Insurability will be required for any person who:
1. Does not apply for this insurance within the first 31 days after first becoming eligible to apply.
2. Applies for an amount of insurance that exceeds the Guaranteed Issue Limit, if applicable.
3. Applies for reinstatement of life insurance coverage after such coverage has been terminated.
4. Converts insurance under this Policy to permanent insurance, and later becomes eligible for coverage under this Policy again.

EFFECTIVE DATE OF COVERAGE

An eligible employee or member must apply for this insurance on a form approved by us, and agree in writing to pay any required premium contributions. Coverage will become effective on:
1. The Policy Effective Date, for Applications submitted and approved by us prior to the Policy Effective Date. Under no circumstances will coverage be effective prior to the Policy Effective Date.
2. The Certificate Effective Date, for Applications submitted and approved by us after the Policy Effective Date.

Except that:
1. If an employee or member is not in Active Service on the day coverage is scheduled to become effective, coverage will become effective on the date he or she returns to Active Service.
2. If a Dependent is not in Active Service (if employed) or is confined in a hospital (if not employed) on the date his or her coverage is scheduled to become effective, coverage will become effective on the day following his or her return to Active Service or discharge from the hospital.

BENEFITS

Employee or Member:
Increments of $10,000, maximum $500,000, not to exceed five times Salary.

Dependents:
Increments of $5,000, maximum $100,000, not to exceed 50% of the employee or member coverage amount.

Salary - means the employee's or member's annualized regular wages rounded up to the next highest $1,000. Salary does not include overtime or bonuses, cash awards, expense allowances, shift differential, goal sharing, variable pay, stock option earnings, incentive items or other extra pay items.

MINIMUM PARTICIPATION REQUIREMENT

A minimum of two eligible employee or members insured is required to issue and keep this Policy in force.

INCLUDED RIDERS

The following optional riders are available with this Policy:

Accelerated Death Benefit for Terminal Illness Rider
Accelerated Death Benefit for Chronic Condition Rider
Waiver of Premium Due to Layoff or Strike Rider
Child Term Insurance Rider

ADDITIONAL AGREEMENTS

None

DEFINITIONS

The provisions of this Policy are subject to the defined terms below.

Active Service - The Insured, if an employee, must be:
1. Performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day; and
2. Performing these duties at one of the places of business where he or she normally works or at some location directed by the employer.

The Insured is considered to be in Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her occupation if it were a scheduled work day and he or she were in Active Service on the last preceding regular work day.

For members, the Insured will be in Active Service if he or she meets the eligibility requirements on the Policyholder Application.

Application - The form completed and signed by your eligible employees or members to apply for coverage under this Policy.

Certificate - The document that describes the terms of the insurance for an insured employee, member or Dependent, as applicable.

Child – A Child of the employee or member who is within the Age range of 15 days through Age 25 and is:
1. A natural child;
2. A legally adopted child, or a child for whom adoption proceedings have begun;
3. A stepchild;
4. A child for whom the employee or member has been appointed legal guardian; or
5. A grandchild who lives with and is financially dependent on the employee or member for support.

Dependent - An employee's or member's Spouse or Other Adult Dependent or Child.

Death Benefit - The amount payable upon the death of an Insured.

Insured - The employee or member or Dependent who is covered under this Policy.

Other Adult Dependent - The employee's or member's common law marriage partner, domestic partner, or civil union partner, if legally required in the governing jurisdiction or as otherwise agreed upon between you and us, who is within the Age range of 16 through 65.

Policy - This document that describes the insurance available to your employees or members.

Policyholder, you, your, or **yours** - The entity named on the cover page of this Policy.

Policyholder Application - The form completed and signed by you to apply for this Policy

Spouse - A person who is legally married to the employee or member, who is within the Age range of 16 through 65.

Tobacco Use - The Insured's use of any of the following tobacco products within the last 12 months: cigarettes, cigars, pipes, snuff, and chewing tobacco, or nicotine replacement products, such as patches or gum. Such Insured would be considered a **Tobacco User**.

We, **us** and **our** - Transamerica Life Insurance Company.

POLICYHOLDER PROVISIONS

Duties - Your duties will include, but are not limited to, the following:

1. Provide us with any and all information we determine to be necessary for the enrollment of your employees or members for the determination of their eligibility. You must provide us with all data we need to underwrite the coverage, to compute premiums, to maintain necessary administrative records, and to generally administer this Policy.
2. Provide us with the completed Applications (or other forms acceptable to us), if applicable.
3. Fulfill the agreements listed on the Policyholder Application.
4. Maintain records pertaining to the insurance of your employees or members as we may reasonably require while this Policy is in force. For two years after this Policy terminates, you must allow us the opportunity to examine these records at any reasonable time during normal business hours.
5. Cooperate fully with us in preparing and/or delivering any notices to your employees or members regarding this insurance.

Certificates - We will issue Certificates for each Insured. The Certificates will describe the life insurance coverage provided by this Policy.

Inspection of Policy - You must make this Policy available for inspection by your employees or members at all reasonable times during normal business hours.

Notice of Right to Convert Coverage - You are required to give each Insured a notice of the right to convert coverage after an Insured ceases to be eligible for coverage under this Policy. Details are set forth in the Conversion Option section of the Certificate.

Notice of Right to Continue Coverage - You are required to give each Insured a notice of the right to continue coverage after an Insured ceases to be eligible for coverage under this Policy. Details are set forth in the Portability Option of the Certificate.

PREMIUMS, POLICY CHANGES, TERMINATION, AND REINSTATEMENT

Premiums – The premiums due will be the sum of the premiums due for all Insureds under this Policy. Premiums are due and payable to us by you on each premium due date. The first premium due date is the Policy Effective Date. Later premiums are due monthly.

The amount of the premium for each Insured is shown on his or her Certificate Schedule.

Who May Change This Policy - The terms of this Policy, including premium rates, may be changed at any time by written agreement between you and us. The insurance provided by this Policy may be changed or canceled without the consent of any Insured and without prior notice to any Insured. Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to this Policy and then only in writing. No agent or Policyholder has authority to change this Policy or to waive any of its provisions. All changes are subject to the laws of the governing jurisdiction.

When Policy Changes are Effective - Unless otherwise agreed upon in writing, the Effective Date of any change in premium or benefits will be the Policy Anniversary Date.

When This Policy Ends – This Policy will terminate at the earliest of the following events:

1. If any premium payable is not paid within its Grace Period, this Policy will terminate on the day after the end of the Grace Period;
2. If you submit a 60-day advance written request to us to terminate the Policy, this Policy will terminate on the date specified in such request;
3. If we give you a 60-day advance written notice that we intend to terminate the Policy, this Policy will terminate on the date specified in such notice;
4. If you fail to comply with any terms of the Policy, or fail to fulfill any obligations under or pertaining to this insurance, or fail to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to this insurance, this Policy will terminate on the 32nd day after we have given you written notice of our intent to terminate.

Termination of this Policy is without prejudice to claims that occur or commence prior to the date of termination.

Grace Period – You have a Grace Period of 31 days from each premium due date, except the first, in which to pay the premium then due. Coverage will continue during the Grace Period. You are liable for the premium during the Grace Period.

When Policy May Be Reinstated – At our sole discretion, we may reinstate the Policy which has terminated if requested to do so by the Policyholder.

GENERAL PROVISIONS

Adjustments in the Event of Clerical Error - Clerical error will not void insurance otherwise validly in force; nor will it continue or make insurance valid that otherwise would cease or would never have been issued.

Adjustments in the Event of Error in Age or Tobacco Use - If the Age or Tobacco Use status of any Insured is misstated on the Application, we will adjust the Death Benefit to reflect the amount that the most recent premium would buy at the Insured's correct Age or Tobacco Use status.

Entire Contract - This Policy, your Policyholder Application, a Certificate evidencing the insurance made available to your employees or members, and any riders, endorsements and amendments constitute the entire contract of insurance.

Non-Participation - This is non-participating insurance. Neither you nor any employee or member participates in our profits or surplus.

Right to Contest - We will not use any statement, except fraudulent statements, to void or reduce benefits under this Policy or any Certificate after it has been in force for two years from its Effective Date. Any such statement would have to be in a signed form. This also applies to all Riders.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you or your representative.

Time Effective - For any dates used in this Policy, the effective time will be 12:01 AM at your address.

CERTIFICATE PROVISIONS MADE A PART OF THIS POLICY

The remainder of this Policy consists of the provisions that appear in the Certificate (including any Riders and/or Endorsements) that describes the insurance made available to your employees or members under this Policy. Copies of the Certificate, any Riders and Endorsements, if any, are attached to and become a part of this Policy.

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499
A Stock Company

FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 1-888-763-7474
PLEASE READ YOUR CERTIFICATE CAREFULLY

GROUP TERM LIFE INSURANCE CERTIFICATE

This Certificate summarizes the Master Policy for Group Term Life Insurance ("Policy") that is underwritten by Transamerica Life Insurance Company (the "Insurer"). Read it carefully to become familiar with your coverage.

Terms important to understanding this Certificate are defined in the **Definitions** section or in separate Certificate Provisions and are capitalized in this Certificate.

The Policy under which this Certificate is issued may be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Owner or Insured. Premiums are subject to periodic changes.

RIGHT TO EXAMINE AND RETURN CERTIFICATE WITHIN 30 DAYS

AT ANY TIME WITHIN 30 DAYS AFTER YOU RECEIVE THIS CERTIFICATE, YOU MAY RETURN IT TO US OR THE GROUP POLICYHOLDER. WE WILL CANCEL THIS CERTIFICATE AND VOID IT FROM THE BEGINNING. WE WILL REFUND TO YOU ANY PREMIUMS PAID.

This Certificate is signed for the Company at our Home Office to take effect on its Effective Date.

General Counsel and Secretary

President

Group Term Life Insurance Certificate

20 Year Term Life Insurance
Renewable to Expiration Date
Premiums Subject to Change
Conversion to Permanent Life Insurance Option
Non-Participating – No Dividends

Administrative Office
PO Box 869094
Plano, TX 75086-9817
1-(888) 763-7474
E-Mail Address: customer service@Transamerica.com
Web Address: www.transamericaworksite.com

TABLE OF CONTENTS

CERTIFICATE SCHEDULE

POLICYHOLDER	FOREST RIVER INC	POLICY NUMBER	T200075492
INSURED	XXXX XXX	CERTIFICATE NUMBER	XXXXX
DEATH BENEFIT	$XX,XXX	EFFECTIVE DATE	XXXXXX
CLASS OF RISK	[TOBACCO]	PREMIUM PAYMENT	$XX.XX MONTHLY
INSURED ISSUE AGE	XX	INITIAL TERM PERIOD	20 Year Term
EXPIRATION DATE	Certificate Anniversary Date following Insured's 100th Birthday		
OWNER	[THE INSURED]		

RIDERS INCLUDED IN YOUR COVERAGE

Accelerated Death Benefit for Terminal Illness Rider
Maximum Benefit: the lesser of: (a) up to 50% of the Insured's Death Benefit; or (b) $100,000
Monthly Premium: $0.00

Waiver of Premium Due to Layoff or Strike Rider
Benefits Stop on the Certificate Anniversary Date following the Insured's 65th birthday
Monthly Premium: Included

Accelerated Death Benefit for Chronic Condition Rider $XX.XX
Percentage of death benefit amount for monthly benefit: 4%
Percentage of death benefit amount for one-time lump sum benefit: 20%
Elimination Period: 90 Days
Maximum Monthly Premium Rate per $1,000: $X.XXXX

Child Term Insurance Rider:
Death Benefit: Each Child: $XX,XXX
Monthly Premium: $X.XX

TABLE OF MAXIMUM ANNUAL PREMIUM RATES

The maximum annual premium for this Certificate will be determined by multiplying the annual rate per $1,000 by the number of $1,000's of Death Benefit amount. These rates do not include the additional premiums payable for any Riders which may be attached to this Certificate. These are annual rates and should be adjusted for other payment methods or modes. Current rates lower than these maximum rates may be charged.

ATTAINED AGE	NON-TOBACCO 20 YEAR TERM* ANNUAL RATE PER $1,000	TOBACCO 20 YEAR TERM * ANNUAL RATE PER $1,000	ATTAINED AGE	NON-TOBACCO 20 YEAR TERM* ANNUAL RATE PER $1,000	TOBACCO 20 YEAR TERM * ANNUAL RATE PER $1,000
16	$ 3.57	$ 4.52	58	$ 21.52	$ 32.68
17	$ 3.57	$ 4.52	59	$ 22.90	$ 34.42
18	$ 3.57	$ 4.52	60	$ 24.50	$ 37.23
19	$ 3.57	$ 4.52	61	$ 26.39	$ 39.76
20	$ 3.57	$ 4.52	62	$ 28.23	$ 42.82
21	$ 3.57	$ 4.52	63	$ 30.13	$ 46.96
22	$ 3.57	$ 4.52	64	$ 33.47	$ 51.57
23	$ 3.57	$ 4.52	65	$ 37.08	$ 58.57
24	$ 3.77	$ 4.62	66	$ 40.39	$ 66.32
25	$ 3.77	$ 4.62	67	$ 43.95	$ 72.03
26	$ 4.00	$ 4.85	68	$ 47.96	$ 77.20
27	$ 4.00	$ 4.85	69	$ 52.30	$ 83.01
28	$ 4.24	$ 5.09	70	$ 67.73	$ 98.08
29	$ 4.24	$ 5.09	71	$ 74.57	$ 109.25
30	$ 4.53	$ 5.35	72	$ 81.66	$ 123.01
31	$ 4.53	$ 5.35	73	$ 95.10	$ 136.86
32	$ 4.85	$ 5.62	74	$ 112.08	$ 153.03
33	$ 4.85	$ 5.62	75	$ 136.35	$ 183.21
34	$ 5.19	$ 5.90	76	$ 149.43	$ 203.95
35	$ 5.42	$ 6.27	77	$ 163.59	$ 225.72
36	$ 5.79	$ 6.87	78	$ 179.42	$ 248.38
37	$ 6.18	$ 7.63	79	$ 196.27	$ 272.66
38	$ 6.42	$ 7.78	80	$ 224.67	$ 299.57
39	$ 6.42	$ 7.91	81	$ 262.78	$ 329.97
40	$ 6.58	$ 7.99	82	$ 306.89	$ 364.70
41	$ 6.91	$ 9.09	83	$ 348.89	$ 404.10
42	$ 7.47	$ 9.89	84	$ 386.65	$ 450.37
43	$ 8.04	$ 10.92	85	$ 429.20	$ 496.61
44	$ 8.72	$ 11.64	86	$ 467.79	$ 549.13
45	$ 8.72	$ 12.67	87	$ 525.89	$ 599.72
46	$ 9.17	$ 13.54	88	$ 586.58	$ 656.92
47	$ 9.36	$ 14.60	89	$ 651.28	$ 711.28
48	$ 9.55	$ 15.56	90	$ 710.91	$ 773.90
49	$ 9.74	$ 16.94	91	$ 741.08	$ 840.64
50	$ 10.95	$ 18.22	92	$ 800.41	$ 913.47
51	$ 12.16	$ 19.50	93	$ 888.45	$ 960.00
52	$ 13.59	$ 20.95	94	$ 960.00	$ 960.00
53	$ 15.04	$ 22.65	95	$ 960.00	$ 960.00
54	$ 16.62	$ 24.37	96	$ 960.00	$ 960.00
55	$ 16.69	$ 26.18	97	$ 960.00	$ 960.00
56	$ 18.49	$ 28.47	98	$ 960.00	$ 960.00
57	$ 20.22	$ 30.99	99	$ 960.00	$ 960.00

* Current premiums are guaranteed for the first 5 Certificate years.

DEFINITIONS

Active Service - The Insured, if an employee, must be:
1. Performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day; and
2. Performing these duties at one of the places of business where he or she normally works or at some location directed by the employer.

The Insured is considered to be in Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her occupation if it were a scheduled work day and he or she were in Active Service on the last preceding regular work day.

For members, the Insured will be in Active Service if he or she meets the eligibility requirements on the Policyholder Application.

Age or **Attained Age** - The Insured's Age as of the last Certificate Anniversary Date. Attained Age will increase by one year on each Certificate Anniversary Date. **Issue Age** is the Attained Age of the Insured as of the Effective Date. The Issue Age is shown on the Certificate Schedule.

Amendment, Endorsement, or **Rider** - Any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provisions or benefits.

Anniversary Date – The month and date of each calendar year that is the same month and date as the Effective Date.

Application - The form completed and signed by the Owner to apply for this life insurance coverage.

Beneficiary - The recipient of the Death Benefit of this Certificate in the event of the Insured's death.

Certificate – This document that describes your insurance coverage.

Death Benefit - The amount payable upon the Insured's death.

Effective Date - The date when the Policy or this Certificate takes effect as shown on the Policy Schedule or Certificate Schedule.

Expiration Date – The date that coverage under this Certificate terminates if the Insured is living on that date.

Grace Period – The Grace Period is a 31-day period after a premium payment is due. See the Grace Period provision in the General Provisions section for details.

Insured - The person covered under this Certificate and named on the Certificate Schedule.

Initial Term Period – The number of years for which the Policy is initially issued.

Lapse - The termination of this Certificate for the nonpayment of premium or insufficient payment of the premium due.

Owner, you, your, or **yours** - The employee or member named as Owner on the Certificate Schedule to which this Certificate is issued.

Policy – The document that is issued to the Policyholder.

Policyholder – The group entity named on the cover page of the Policy.

Reinstate, **Reinstated,** or **Reinstatement** - To restore coverage if this Certificate has Lapsed, subject to the Reinstatement provision.

Tobacco Use – The Insured's use of any of the following tobacco products within the last 12 months: cigarettes, cigars, pipes, snuff, and chewing tobacco, or nicotine replacement products such as patches or gum. Such Insured would be considered a **Tobacco User**.

Transamerica Life Insurance Company, the Company, we, us, or **our** – The Insurer that underwrites this life insurance coverage and pays the benefits upon a claim.

OWNERSHIP

You have certain rights while the Insured is living and this Certificate is in force. Your rights include, but are not limited to, those listed below:

1. Changing the Beneficiary, subject to any irrevocable Beneficiary that may have been named (an irrevocable Beneficiary cannot be changed without the written consent of that irrevocable Beneficiary);
2. Assigning any right or benefit under this Certificate;
3. Reinstating coverage that has Lapsed, subject to the Reinstatement provision;
4. Exercising an option under any Rider attached to this Certificate; and
5. Transferring ownership. Any requested change of ownership must be in writing on our form and approved by us. Your requested change will be effective on the date that you signed it, subject to any actions taken prior to receipt of such change.

If you, as the Owner, are not the Insured, and you die before the Insured, the executor or administrator of your estate will have these rights.

BENEFICIARY

Payment of the Death Benefit - If the Insured dies while this Certificate is in force, we will pay the Death Benefit to the Beneficiary, subject to the provisions of this Certificate. The Beneficiary will be as designated on the Application for this insurance coverage, unless later changed as provided under the How to Change the Beneficiary provision.

If a Beneficiary is Not Named in the Application or the Stated Beneficiary Dies - The rights of any Beneficiary to receive the Death Benefit will end if the Beneficiary dies prior to the death of the Insured. Except to the degree that benefits have already been paid, and unless otherwise provided, the rights of any Beneficiary who dies at the time of, or within 30 days after, the Insured's death will end at their death. If the rights of all named Beneficiaries have ended, or if a Beneficiary was not named in the original Application, benefits will be payable to the Insured's survivors in the following order of preference:

1. Spouse or Other Adult Dependent;
2. Child(ren) (in equal amounts);
3. Parents (in equal amounts);
4. Siblings (in equal amounts);
5. The executor or administrator of the Owner's estate.

The existence of multiple Beneficiaries will not increase the benefit payable.

Protection of the Death Benefit - To the extent permitted by law, the Death Benefit will not be subject to the claims of the Beneficiary's creditors or to any legal process against the Beneficiary.

How to Change the Beneficiary - You may change the Beneficiary at any time while the Insured is living. Please request a Change of Beneficiary form from us. To be effective, the change must be in writing and signed by both you and a disinterested witness. The change will be effective on the date it is recorded. However, any benefits paid before we receive the notice of a change in Beneficiary will not be subject to such change. If the Insured dies after you changed the Beneficiary, but before the date it is recorded, the change will be effective on the date you signed the valid change request.

DEATH BENEFIT

The Death Benefit payable at the Insured’s death will be:

1. The Death Benefit in effect at the Insured’s death; plus
2. Any insurance on the Insured’s life provided by Riders, if any; less
3. Any premium which is due and unpaid for a period from the premium due date to the end of the Certificate month in which the Insured’s death occurs.

Death Benefit - The Death Benefit is the amount shown on the Certificate Schedule.

Refund of Unearned Premium - We will refund any unearned life insurance premium upon the death of the Insured. Such refund will be made to the designated Beneficiary and will be included with the Death Benefit.

RENEWAL PROVISION

The Initial Term Period will be for the number of years shown on the Certificate Schedule. After the Initial Term Period, you may renew this Certificate for successive term periods. The successive term periods will be for the same number of years as the Initial Term Period or the period ending at the Expiration Date, if earlier. No evidence of insurability is required on renewal. Renewal will automatically take place on each Policy Anniversary on or following the end of a Term Period provided:

1. The Policy and this Certificate are in force with no premium in default; and
2. The premium due on the Policy Anniversary is paid within the Grace Period.

Upon payment of such renewal premium, any Riders which are part of this Certificate may be continued on renewal of this Certificate, subject to their termination provisions.

EFFECTIVE DATE

The insurance under this Certificate will start on the Certificate Effective Date if:

1. Your Application has been approved by us on or before this date;
2. The Insured is living; and
3. The initial premium payment has been received by us.

If the Insured is not in Active Service (if employed) or is confined in a hospital (if not employed) on the Certificate Effective Date, then coverage will not become effective until the day after the Insured returns to Active Service or is discharged from the hospital.

PREMIUMS

Premium Payments – The premium payable for this Certificate is shown on the Certificate Schedule. The first premium must be paid on or before the Certificate Effective Date. Premiums are payable in advance of the period to which they apply. All premiums are payable to our Administrative Office or to an agent authorized by us to collect premiums.

Change of Premium – We reserve the right to decrease or increase the current premiums after the period of time shown on the Certificate Schedule. However, premiums will never exceed the maximum guaranteed premiums shown on the Certificate Schedule. We will notify you at least 31 days prior to the date a change in premium amount is effective. We will send you a notice of your new current premium.

TERMINATION

The insurance under this Certificate will stop on the earliest one of these occurrences:

1. The date we receive your written request to terminate coverage;
2. The Expiration Date;
3. The date the Insured dies;
4. The date this Certificate Lapses, subject to the Grace Period; or
5. The date the Policy terminates, subject to the Portability Option.

REINSTATEMENT

This Certificate may be Reinstated within five years after default in payment. Reinstatement is subject to:

1. Proof of insurability satisfactory to us; and
2. Payment of past due premiums with interest compounded annually at 6% per year.

The Right to Contest provision applies from the effective date of Reinstatement. If this Certificate has been in force for two years during the lifetime of the Insured, it is contestable only as to statements made in the Reinstatement Application.

CONVERSION OPTION

You can convert the Insured's coverage to permanent life insurance on a policy form that we then issue, without any optional Riders, in an amount not to exceed the amount of insurance that is terminating under the Policy. The premium for the permanent coverage will be based upon the Insured's Attained Age and class of risk at the time of conversion, together with the form and amount of insurance chosen. No evidence of insurability will be required.

We must receive the conversion application and any required premium within 31 days of termination under the Policy. If the Insured dies within the 31-day conversion period, benefits under the Policy will be paid as if coverage had continued, regardless of whether or not the Owner applied for conversion coverage.

Conversion is not available if termination is the result of submitting a fraudulent claim.

PORTABILITY OPTION

If you lose eligibility for this insurance for any reason other than nonpayment of premiums and while the Policy is still in force, you will have the option to continue this Certificate (including any Riders) by paying the premiums directly to us at our Administrative Office. We will bill you for these premiums. The premiums you pay directly to us may include an additional charge for administrative costs.

Premiums may be paid annually, semi-annually, quarterly or monthly, subject to our rules as of the date you request portability. The Owner may change the frequency of premium payments, subject to our rules in effect at the time of the change by filing a written request at our Administrative Office. If you stop paying the premiums under this option, this Certificate (and any Riders) will cease, subject to the terms of the Grace Period.

GENERAL PROVISIONS

Assignment - If you file an assignment with us and it is recorded at our Administrative Office, your rights and the rights of the Beneficiary will be subject to that assignment.

Claims Procedure - Due proof of the Insured's death must be submitted to us at our Administrative Office. The Beneficiary or a personal representative can get a claim form by calling our toll-free telephone number listed on the cover page.

Entire Contract - The Policy, the Policyholder Application, this Certificate, your Application and any Riders, Endorsements and Amendments form the entire contract of insurance. All statements made by or for an Insured, in the absence of fraud, will be considered representations and not warranties. We will not use any statement made by or for an Insured to contest this insurance unless:

1. That statement is in writing;
2. That statement has been signed by, or on behalf of, the Insured; and
3. A copy of that statement has been given to the Insured, his or her Beneficiary or personal representative.

Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy, this Certificate, or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Grace Period – If we do not receive a premium payment when it is due, a Grace Period of 31 days will be provided. Written notice will be sent to your last known address on record at least 31 days prior to termination. If a premium payment is not paid by the end of the Grace Period, this Certificate will terminate. If the Insured dies during the Grace Period, we will pay the Death Benefit, less any unpaid premium.

Policyholder as Your Agent - For all purposes related to this insurance, your Policyholder serves as your agent and not as our agent.

Misstatement of Age or Tobacco Use Status - If the Insured's Age or Tobacco Use status was misstated on the Application for this insurance coverage, we will adjust the Death Benefit to the amount that the most recent premium would buy at the Insured's correct Age or Tobacco Use status.

Right To Contest - We will not contest this insurance, in the absence of fraud, after it has been in force during the lifetime of an Insured for two years from the date it starts, except for nonpayment of premiums.

Suicide Exclusion - We will not pay a Death Benefit if an Insured dies by suicide, while sane or insane, within two years of the date his or her insurance starts. If the Insured dies by suicide within this two-year period, we will refund the premiums paid for the insurance.

When Notice is to be Given by Us - Any notice to be given by us will be sent to the Owner at the Owner's last known address and any assignee of record at the assignee's last known address.

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: PO Box 869094 Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

CHILD TERM INSURANCE RIDER

This Rider is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail. This Rider has no cash value.

DEFINITIONS

In addition to the definitions contained in the Contract, the following definition applies to this Rider;

Insured Child - A Child of the Insured who is within the Age range of 15 days through Age 25 and is:
1. A natural child;
2. A legally adopted child, or a child for whom adoption proceedings have begun;
3. A stepchild; or
4. A child for whom the employee or member has been appointed legal guardian.

To become an Insured Child after the date of the Application, a child must meet the above definition and the Insured must complete an Application to add the new child as an Insured Child.

BENEFIT

We agree to pay the Rider Death Benefit to the Beneficiary when we receive due proof that an Insured Child died on or before the Expiry Date of this Rider. The Rider Death Benefit with respect to each Insured Child is shown on the Certificate Schedule.

GENERAL RIDER PROVISIONS

Contestability – This Rider will be contestable on the same basis as the contract, during the lifetime of the Insured, for two years from the Rider Effective Date.

Suicide – The Suicide provision in the Contract does not apply to this Rider.

PREMIUM

The premium for this Rider is shown on the Certificate Schedule.

EFFECTIVE DATE

The Rider Effective Date is the same date as the contract Effective Date unless we inform the Owner in writing of a different date.

TERMINATION

Expiry Date - Is the Certificate Anniversary after the last Insured Child covered under this Rider has reached his or her 26th birthday.

Termination - The term insurance on an Insured Child will terminate on the earliest of the following dates:
1. The date the contract terminates, subject to the Conversion Options of this Rider;
2. The date this Rider or the contract Lapses for failure to pay premium, subject to the Grace Period of the contract.
3. The date the Owner requests termination.
4. The Certificate Anniversary following the date the Insured Child is no longer eligible as a dependent child.
5. The Expiry Date of this Rider.

Our acceptance of a premium for any period after the date of termination of this Rider will create no liability for us, nor will it constitute a waiver of the termination. Any such premium will be returned.

Termination will not affect any claim which occurred prior to termination.

CONVERSION OPTIONS

Conversion and Transfer of Ownership due to Death of Owner - If the Owner dies while this Rider is in force, the premium and deduction will be waived and coverage on any Insured Child under this Rider will automatically be changed to paid-up insurance. This paid-up insurance will have no cash or loan values and will automatically terminate on each Insured Child's 26th birthday. The Owner of the paid-up insurance will be the Insured Child unless such Insured Child is a minor, in which case Ownership will pass to the executor or administrator of the Insured Child's estate for disposition.

Conversion to Individual Policy - When the coverage of an Insured Child terminates for any reason other than the non-payment of premium, the Insured Child may convert this Rider to permanent life insurance on a policy form that we then issue, without any riders, for the then current rates and limits, without further evidence of insurability. The following conditions must be met in order for Conversion to occur:

1. We must receive the conversion application and any required premium at our Administrative Office within 31 days of the termination or expiry of coverage under this Rider.
2. Coverage under the new policy will become effective on the date such Application is made and the premium is paid.
3. The amount of insurance under the new policy may be increased to the lesser of:
   a. Five times the Rider Face Amount at the termination date, or
   b. $50,000.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

ACCELERATED DEATH BENEFIT FOR CHRONIC CONDITION RIDER

(Living Benefit Rider)

The Death Benefit will be reduced if any Accelerated Death Benefit is paid.

SPECIAL NOTICE

Benefits received under this Rider may be taxable as income. Whether any tax liability is incurred when benefits are paid under this Rider could depend on whether your employer has paid the premium, and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult an independent tax advisor to evaluate any tax impact of this benefit.

Receipt of an Accelerated Death Benefit may adversely affect eligibility for Medicaid or other government benefits or entitlements. Without exercising this option, the mere fact that this Rider is part of your contract will not, in and of itself, affect the eligibility for these government programs. However, exercising this option before you apply for these programs, or while you are receiving government benefits, may affect your continued eligibility. Contact the Medicaid Unit of the local Department of Public Welfare and/or the Social Security Administration Office for more information.

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider will apply to this Rider. This Rider has no cash value.

NOTICE TO YOU, THE OWNER

FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 1-888-763-7474

This Rider is not long term care insurance and does not provide long term care insurance, nor is it intended to replace long term care insurance coverage. We advise you to review carefully all limitations of this Rider, as well as those of the contract to which it is attached.

DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

Activities of Daily Living – For the purposes of this Rider, each of the following activities is considered an Activity of Daily Living:

Bathing - The Insured's ability to wash himself or herself by sponge bath; or in a tub or shower, including the task of getting into and out of the tub or shower.

Continence – The Insured's ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing - The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating - The Insured's ability to feed himself or herself by getting food into his or her body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Toileting – The Insured's ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.

Transferring - The Insured's ability to move into or out of a bed, chair or wheelchair.

Chronic Condition –

1. The inability, expected to be permanent, to perform, without Substantial Human Assistance, at least two Activities of Daily Living for a period of at least 90 days; **or**
2. Severe Cognitive Impairment that is expected to be permanent and that requires Substantial Supervision to protect the Insured from threats to his or her health and safety.

Death Benefit Amount – The amount of the Death Benefit in effect on the date immediately following the date the Insured first satisfies the Eligibility for Benefits provision.

Elimination Period – The number of consecutive days during which the Insured must meet the Eligibility for Benefits requirements listed under the Benefits provision. During the Elimination Period no benefits are payable under this Rider. The Elimination Period starts on the day the Insured's Chronic Condition begins, as stated in a Physician's certification. The Elimination Period for this Rider is shown in the Certificate Schedule. The Elimination Period needs to be satisfied only once during the Insured's lifetime.

Immediate Family Member – Anyone related to an Insured in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or the spouse of any of these. The term "spouse" includes a common law marriage partner, domestic partner, or civil union partner, if legally recognized in the governing jurisdiction.

Medicare – The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Physician –
1. A doctor of medicine or osteopathy as set forth in Section 1861(r)(1) of the Social Security Act, as amended, who is legally authorized to practice medicine and surgery within the United States by the jurisdiction in which he or she performs such function or action; and
2. Is not an Immediate Family Member.

Severe Cognitive Impairment – A severe loss or deterioration in intellectual capacity that is comparable to and includes advanced Alzheimer's disease and is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in the Insured's:
1. short-term or long-term memory;
2. orientation as to person, place and time;
3. deductive or abstract reasoning; or
4. judgment as it relates to safety awareness.

The evaluation shall include utilizing cognitive tests with resulting scores consistent with a diagnosis of Severe Cognitive Impairment.

Substantial Human Assistance – Actual hands-on assistance by another individual.

Substantial Supervision – Continuous supervision, including but not limited to verbal cueing, by another individual to protect the Insured from harming himself, herself or others, or from threats to the Insured's health and safety.

BENEFITS

Eligibility for Benefits – We will pay an Accelerated Death Benefit under this Rider after we receive written proof of loss that the Insured has met ***all*** of the following conditions:
1. A Physician has certified that the Insured has a Chronic Condition;
2. The Insured has satisfied the Elimination Period; and
3. The contract to which this Rider is attached is in force.

Accelerated Death Benefit Options
You may choose one of the following options for submitting a claim for an Accelerated Death Benefit under this Rider:

Option 1 – Monthly Accelerated Death Benefit – You may request a monthly Accelerated Death Benefit equal to the applicable percentage of the Death Benefit Amount shown on the Certificate Schedule. This benefit is payable for each month the Insured satisfies the Eligibility for Benefits provision while this Rider is in force. After submitting satisfactory proof of loss, in order to continue receiving the monthly benefit you must provide, every 90 days, a written certification by a Physician that the Insured continues to have a Chronic Condition.

Option 2 - One-Time Lump Sum Accelerated Death Benefit – In lieu of the monthly Accelerated Death Benefit, you may request a one-time lump sum Accelerated Death Benefit payment equal to the applicable percentage shown on the Certificate Schedule of the Death Benefit Amount. Upon payment of this lump sum benefit, your rights under this Rider will end and this Rider will terminate.

Waiver of Monthly Premium – We will waive the monthly premium for each contract month or partial contract month that you receive benefits under this Rider. If you elect the one-time lump sum Accelerated Death Benefit option, this waiver provision will not apply.

Concurrent and/or Subsequent Chronic Conditions
If the Insured suffers from more than one Chronic Condition, we will pay an Accelerated Death Benefit under this Rider for only one of the conditions. Under no circumstances will we pay an Accelerated Death Benefit for any subsequent Chronic Condition under this rider.

A separate claim must be submitted for consideration under any other Accelerated Death Benefit Rider attached to the contract.

Payment of an Accelerated Death Benefit under this Rider will not reduce any Accidental Death benefit available under the contract.

EFFECT ON INSURED'S DEATH BENEFIT

If the Owner receives Accelerated Death Benefit payments in accordance with this Rider, we will deduct any amounts paid under this Rider from the Death Benefit. The Beneficiary will receive any remaining amount of the Death Benefit after the Insured dies, provided the contract has not terminated. However, if the entire Death Benefit proceeds are paid under the terms of this Rider prior to the Insured's death, the Contract will terminate and there will be no Death Benefit payable upon the Insured's death.

The Death Benefit will be reduced by the amount of the Accelerated Death Benefit.

If you elect monthly Accelerated Death Benefit payments under this Rider, the following conditions will apply during the period that such payments are being made.
1. You cannot change the Death Benefit of the Contract, or add any Riders.
2. We will not accept any premium payments.

If monthly Accelerated Death Benefit payments are made, we will provide a monthly report that shows the effect each benefit payment has on the Death Benefit.

EXCLUSIONS AND LIMITATIONS

We will **not** pay Rider benefits if the Insured meets the requirements of the Eligibility for Benefits provision as a result of:
1. An intentionally self-inflicted injury or attempted suicide.
2. War or any act of war, declared or undeclared, or service in the armed forces of any country.
3. The Insured's alcohol, drug or other chemical dependence, except if the drug dependency is for a drug prescribed by a Physician in the course of treatment for an injury or sickness.
4. The Insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the Insured's involvement in an illegal activity.

CLAIMS

The following Claims Procedures apply to this Rider.

Notice of Claim – Written notice of claim must be given to us at our Administrative Office or to our agent. Such notice of claim should be made within 30 days after a Physician determines the Insured has a Chronic Condition. If it is not reasonably possible to give notice of claim within that time, the claim may not be denied or reduced due to the delay, so long as notice of claim is given as soon as reasonably possible.

Claim Forms – Claim forms should be used for filing proof of loss. We will send such form to the claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, you can give proof of loss in writing, setting forth the nature and extent of the loss within the time stated in the proof of loss provision. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page of the contract. Such initial notice of claim and ongoing written proof of loss must be sent within the time limit stated in the following paragraph.

Proof of Loss – Due written proof of loss must be given to us at our Administrative Office. We must receive the initial proof of loss within 90 days after the expiration of the Elimination Period.

Failure to furnish such proof of loss within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof of loss and it was furnished as soon as reasonably possible. In any event, the proof of loss required must be given no later than one year from the time proof of loss is otherwise required, unless the claimant was legally incapacitated.

If you submit a claim under the Monthly Accelerated Death Benefit option, we will require subsequent proof of loss to be submitted periodically after the Insured satisfies the Eligibility for Benefits provision. This means submitting, every 90 days, certification by a Physician that the Insured continues to have a Chronic Condition.

Physical Examinations – We have the right to have an Insured examined by a Physician of our choice as often as reasonably necessary while a claim is pending. We will pay for such examination.

Time of Payment of Claims – Benefits for a covered loss will be paid as soon as we receive due written proof of loss.

Payment of Claims – Benefits are payable to the Owner or a payee designated by the Owner.

Legal Actions - No legal action may be brought to recover under the contract within 60 days after written proof of loss has been provided to us as required nor more than three years from the time written proof of loss is required to be furnished.

GENERAL RIDER PROVISIONS

Consent For Benefit Payment – If there is an assignment of this contract on record or an irrevocable Beneficiary on record, we must obtain the consent of any assignee or irrevocable Beneficiary before any Rider benefit is paid.

Contestability – This Rider will be contestable on the same basis as the contract, during the lifetime of the Insured, for two years from the Rider Effective Date.

Suicide – If the Insured dies by suicide, while sane or insane, within two years from the Rider Effective Date, any premiums refunded under the Suicide Exclusion provision of the contract will be reduced by the amount of Accelerated Death Benefits paid, if any, under this Rider.

RIDER COST

The current monthly premium and the maximum monthly premium amount for this rider are shown on the Certificate Schedule. We may use premium rates lower than the maximum rate but will not use rates higher than the maximum rate.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract unless we inform the Owner in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:

1. The date the contract terminates;
2. The date the contract Lapses, subject to the Grace Period;
3. The date the Owner requests termination;
4. The date the Insured dies;
5. The date on which cumulative monthly Accelerated Death Benefit payments equal 100% of the Death Benefit Amount, subject to any rights under an optional Extension of Benefits Rider;
6. The date on which we pay a one-time lump sum Accelerated Death Benefit payment in lieu of any monthly Accelerated Death Benefit

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

Blake Bostwick
President

Jay Orlandi
Secretary

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

DISCLOSURE UPON THE PURCHASE OF THE ACCELERATED DEATH BENEFIT FOR CHRONIC CONDITION RIDER

SPECIAL NOTICE

Benefits received under this Rider may be taxable as income. Whether any tax liability is incurred when benefits are paid under this Rider could depend on whether your employer has paid the premium, and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult an independent tax advisor to evaluate any tax impact of this benefit.

Receipt of an Accelerated Death Benefit may affect eligibility for Medicaid or other government benefits or entitlements. Unless you exercise this option, the mere fact that this Rider is part of your contract will not, in and of itself, affect the eligibility for these government programs. However, exercising this option before you apply for these programs, or while you are receiving government benefits, may affect your continued eligibility. Contact the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office for more information.

This disclosure is designed to provide you with a summary of the Rider coverage. The Rider form and the life contract set forth in detail the terms, conditions, limitations and exclusions of your coverage. Therefore, if you purchase this coverage, it is important that you **READ YOUR LIFE INSURANCE CONTRACT AND ALL RIDERS CAREFULLY.**

If you have any questions or concerns about any benefits or provision of your Accelerated Death Benefit For Chronic Condition Rider, please contact your agent or us directly at 1-888-763-7474.

1. **Benefits -** After our receipt of written proof that an Insured has met the Eligibility for Benefits provision, the Owner may choose to receive a portion of the Death Benefit while the Insured is still alive and while the Rider is in force, until the entire Death Benefit has been paid out.

   Eligibility for Benefits - We will pay an Accelerated Death Benefit under this Rider after we receive written proof that the Insured has met *all* of the following conditions.
   1. A Physician has certified that the Insured has a Chronic Condition;
   2. The Insured has satisfied the Elimination Period; and
   3. The contract to which this Rider is attached is in force.

   Accelerated Death Benefit Options – You may choose one of the following options for submitting a claim for an Accelerated Death Benefit under this Rider:

   Option 1 – Monthly Accelerated Death Benefit – You may request a monthly Accelerated Death Benefit equal to the applicable percentage of the Death Benefit Amount shown on the Certificate Schedule. This benefit is payable for each month the Insured satisfies the Eligibility for Benefits provision while this Rider is in force. After submitting satisfactory proof of loss, in order to continue receiving the monthly benefit you must provide, every 90 days, a written certification by a Physician that the Insured continues to have a Chronic Condition.

   Option 2 - One-Time Lump Sum Accelerated Death Benefit – In lieu of the monthly Accelerated Death Benefit, you may request a one-time lump sum Accelerated Death Benefit payment equal to the applicable percentage shown on the Certificate Schedule of the Death Benefit Amount. Upon payment of this lump sum benefit, your rights under this Rider will end and this Rider will terminate.

   Concurrent and/or Subsequent Chronic Conditions
   If the Insured suffers from more than one Chronic Condition, we will pay an Accelerated Death Benefit under this Rider for only one of the conditions. Under no circumstances will we pay an Accelerated Death Benefit for any subsequent Chronic Condition under this rider.

   A separate claim must be submitted for consideration under any other Accelerated Death Benefit Rider attached to the contract.

Payment of an Accelerated Death Benefit under this Rider will not reduce any Accidental Death benefit available under the contract.

2. **Definitions -** These are some of the important definitions that will help you understand the Benefits provision.

   Activities of Daily Living – For the purposes of this Rider, each of the following activities is considered an Activity of Daily Living:
   Bathing - The Insured's ability to wash himself or herself by sponge bath; or in a tub or shower, including the task of getting into and out of the tub or shower.
   Continence – The Insured's ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
   Dressing - The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
   Eating - The Insured's ability to feed himself or herself by getting food into his or her body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
   Toileting – The Insured's ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.
   Transferring - The Insured's ability to move into or out of a bed, chair or wheelchair.

   Chronic Condition –
   a. The inability, expected to be permanent, to perform, without Substantial Human Assistance, at least two Activities of Daily Living for a period of at least 90 days; **or**
   b. Severe Cognitive Impairment that is expected to be permanent and that requires Substantial Supervision to protect the Insured from threats to his or her health and safety.

   Severe Cognitive Impairment – A severe loss or deterioration in intellectual capacity that is comparable to and includes advanced Alzheimer's disease and is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in the Insured's:
   1. short-term or long-term memory;
   2. orientation as to person, place and time;
   3. deductive or abstract reasoning; or
   4. judgment as it relates to safety awareness.

   Elimination Period – The number of consecutive days during which the Insured must meet the conditions listed under the Benefits provision and during which no benefits are payable under this Rider. The Elimination Period starts on the day the Insured's Chronic Condition begins, as stated in the Physician's certification. The Elimination Period for this Rider is shown on the Contract Data Pages. The Elimination Period needs to be satisfied only once during the Insured's lifetime.

3. **Premiums –** The current monthly premium and the maximum monthly premium amount for this rider are shown on the Certificate Schedule. We may use premium rates lower than the maximum rate but will not use rates higher than the maximum rate.

4. **Waiver of Monthly Premium –** For each month or partial month that benefits are paid under this Rider, we will waive the monthly premium for the contract. If you elect the one-time lump sum Accelerated Death Benefit option, this waiver provision will not apply.

5. **Exclusions** - We will **not** pay Rider benefits if the Insured meets the requirements of the Eligibility for Benefits provision as a result of:
   a. An intentionally self-inflicted injury, or attempted suicide;
   b. War or any act of war, declared or undeclared, or service in the armed forces of any country;
   c. The Insured's alcohol, drug or other chemical dependence, except if the drug dependency is for a drug prescribed by a Physician in the course of treatment for an injury or sickness; or
   d. The Insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the Insured's involvement in an illegal activity.

6. **Impact on Death Benefit –** We will deduct any amounts paid under this Rider from the Insured's Death Benefit and send the Owner a monthly report showing the effect of each payment on the Insured's Death Benefit. The Insured's beneficiary will receive any remaining Death Benefit after the Insured dies, provided the contract has not stopped. However, if the entire Death Benefit has been accelerated prior to the Insured's death, the contract will terminate and there will be no Death Benefit payable upon the Insured's death.

   Once Rider benefit payments begin, you cannot change the Death Benefit of the contract or add any Riders, and we will not accept any premium payments.

   Illustrative Example of the effect of exercising the Accelerated Death Benefit option based on monthly benefit acceleration of 4% of the Death Benefit:

	Death Benefit	Accelerated Death Benefit Amount	Accumulation Value	Surrender Charge
Before payment of Accelerated Benefit	$50,000		$5,000	$500
After one month's payment of Accelerated Death Benefit:	$48,000	$2,000	$4,800	$480

Acknowledgment

I acknowledge that I have read this disclosure and understand that if I exercise the Accelerated Death Benefit option, any Beneficiary I designate may receive either a reduced Death Benefit or no Death Benefit at all. If the entire Death Benefit is paid out as an Accelerated Death Benefit prior to the Insured's death, the Beneficiary I designate will receive no Death Benefit.

_____

Date Owner's Signature

Please return a signed copy to Our Administrative Office address shown at the top of this form

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

(The Death Benefit under the contract will be reduced if a Rider benefit is paid)

SPECIAL NOTICE

This Rider is intended to provide a qualified accelerated death benefit that is excluded from gross income for federal income tax purposes. Whether any tax liability may be incurred when benefits are paid under this Rider could depend on whether you are also the Insured and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult an independent tax advisor to evaluate any tax impact of this benefit.

Receipt of acceleration of life insurance benefits may affect your, your spouse's or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI) and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect you, your spouse's and your family's eligibility for public assistance.

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the contract will prevail. This Rider has no cash value.

DEFINITIONS

Immediate Family Member - The Owner or the Insured (if they are not one and the same) and his or her Spouse or Other Adult Dependent as well as his or her Child, brother, sister, mother or father, or the spouse of one of these individuals.

Physician - A duly licensed or certified practitioner of medicine, other than an Immediate Family Member, who is legally licensed to diagnose and treat any sickness or injury within the scope of his or her license.

Terminal Illness – Is an illness that, in the best medical judgment of a Physician, will result in death within 12 months.

BENEFIT

We will pay an accelerated death benefit under this Rider if the Insured is diagnosed with a Terminal Illness for the *first* time, *on or after* the Rider Effective Date. The maximum amount that you can accelerate is shown on the Certificate Schedule.

EFFECT ON INSURED'S DEATH BENEFIT

If you exercise this option, we will deduct the amount we accelerate from the Insured's Death Benefit. The Insured's Beneficiary will receive the remaining amount of the Death Benefit after the Insured dies, provided the contract has not stopped. After payment of an accelerated death benefit, we will send you a benefit report that will show the proportionate reduction in the premiums under the contract, if any.

LIMITATIONS

We will not pay an accelerated death benefit under this Rider for any Terminal Illness that is diagnosed for the *first* time, prior to the Rider Effective Date.

We will pay an accelerated death benefit only once. If you ask for less than the maximum amount available when you submit a claim, you cannot ask us at a later time to give you the difference between what you did ask for and what you could have asked for.

CLAIMS

The following Claims Procedures apply to this Rider.

Notice of Claim - We must be notified of a claim for benefits under this Rider, in writing, within 30 days of the initial date that the Insured is first diagnosed with a Terminal Illness. The written notice must be sent to our agent or to us. The notice must include sufficient information to identify the claimant. If notice cannot reasonably be given within 30 days of a loss, notice must be sent as soon as reasonably possible.

Claim Forms - After we receive notice of claim, we will send you the claim forms within 15 days. If the forms have not been received within 15 days, you may send us written proof of loss describing the nature and extent of the claim. The written proof of loss must be sent to us within the time limit stated in the following paragraph.

Written Proof of Loss - We will pay benefits under this Rider after we receive written proof of loss. We must receive such proof within 90 days after the Insured is diagnosed with a Terminal Illness. If it is not reasonably possible to provide this information within such time, written proof of loss must be submitted as soon as reasonably possible but no later than one year from the time specified.

Written proof of loss means a written statement signed by a Physician certifying that the Insured has been diagnosed with a Terminal Illness for the ***first*** time. Such certification must also show the date of the original diagnosis and the specific condition diagnosed.

Physical Examination - At our expense, we reserve the right to have a Physician of our choosing examine the Insured while a claim is pending to determine eligibility for benefits. In the event that the Physician we choose provides a different diagnosis of the condition, we reserve the right to rely on the certification from the Physician of our choosing for claim purposes.

Time of Payment of Claims - All benefits described in this Rider will be paid as soon as we have received written proof of loss satisfactory to us.

Payment of Claims - We will pay the accelerated death benefit under this Rider to the Owner, unless a different payee is designated.

Legal Actions - No legal action may be brought to recover under the contract within 60 days after written proof of loss has been provided to us as required nor more than 3 years from the time written proof of loss is required to be furnished.

GENERAL RIDER PROVISIONS

Consent for Benefit Payment: If there is an assignment of the contract on record or an irrevocable Beneficiary on record, we must obtain the consent of such assignee or irrevocable Beneficiary before any Rider benefit is paid.

Contestability - This Rider will be contestable on the same basis as the contract, during the lifetime of the Insured, for two years from the Rider Effective Date.

Suicide: If the Insured dies by suicide, while sane or insane, within two years from the Rider Effective Date, any premiums refunded under the Suicide Exclusion provision of the contract will be reduced by the amount of accelerated benefits paid, if any, under this Rider.

PREMIUM

There is no cost for this Rider, unless you decide to exercise this option. If you decide to exercise this option, you will have to pay:

1. An administrative fee of $100; and
2. 12 months interest, in advance, on the amount that we accelerate. The interest rate will not exceed the greater of:
   a. The current yield on ninety (90) day Treasury bills; or
   b. The current maximum statutory adjustable policy loan interest rate.

EFFECTIVE DATE

The Rider Effective Date is the same date as the contract Effective Date unless we inform the Owner in writing of a different date.

TERMINATION

This Rider stops at the earlier of:
1. The date the contract terminates;
2. The date the Insured dies; or
3. The date we have paid the accelerated death benefit for the Insured.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa 52499
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

DISCLOSURE UPON THE PURCHASE OF THE ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

SPECIAL NOTICE

This Rider is intended to provide a qualified Accelerated Death Benefit that is excluded from gross income for federal income tax purposes. Whether any tax liability may be incurred when benefits are paid under this Rider could depend on whether you are also the Insured and how the Internal Revenue Service interprets applicable provisions of the Internal Revenue Code. As with any tax matter, you and any other recipient of this benefit should each consult an independent tax advisor to evaluate any tax impact of this benefit.

Receipt of an accelerated Death Benefit MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") eligibility. Without exercising this option, the mere fact that the Accelerated Death Benefit for Terminal Illness Rider is part of your contract will not in and of itself affect the eligibility for these government programs. However, exercising this option before you apply for these programs, or while you are receiving government benefits, may affect your continued eligibility. Contact the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office for more information.

This disclosure is designed to provide you with a summary of the Rider coverage. The Rider form and the life contract set forth in detail the terms, conditions, limitations and exclusions of your coverage. Therefore, if you purchase this coverage, it is important that you **READ YOUR LIFE INSURANCE CONTRACT AND ALL RIDERS CAREFULLY.**

If you have any questions or concerns about any benefits or provision of your Accelerated Death Benefit For Terminal Illness Rider, please contact your agent or us directly at 1-888-763-7474.

1. **Description of Benefit -** Upon receipt of written proof acceptable to us that the Insured has 12 months or less to live because of a Terminal Illness, the Owner may choose to receive a portion of the Death Benefit while the Insured is still alive and while the Rider is in force.

   We will pay an accelerated death benefit under this Rider if the Insured is diagnosed with a Terminal Illness for the *first* time, *on or after* the Rider Effective Date. The Terminal Illness Accelerated Death Benefit amount will be equal to the lesser of: (1) up to 50% of the Death Benefit; or (2) $100,000.

   A **Terminal Illness** is an illness that in the best medical judgment of a Physician will result in death within 12 months.
2. **Premiums -** There is no cost for this Rider, unless the Owner exercises this option. If the Owner exercises this option, an administrative fee of $100 will be assessed. In addition, we will deduct 12 month's interest in advance on the amount. The interest rate will not exceed the greater of the current yield on ninety (90) day Treasury bills; or the current maximum statutory adjustable policy loan interest rate.
3. **Effect on Death Benefit -** If you exercise this option, we will deduct the amount we accelerate from the Insured's Death Benefit. The Insured's Beneficiary will receive the remaining amount of the Death Benefit after the Insured dies, provided the contract has not stopped. After payment of an accelerated death benefit, we will send you a benefit report that will show the proportionate reduction in the premiums under the contract, if any
4. **Illustrative Example** of the effect of exercising the Accelerated Death Benefit option based on acceleration of 50% of the Death Benefit:

	Death Benefit	Accelerated Death Benefit Amount
Before payment of Accelerated Benefit	$50,000	$0
After payment of Accelerated Benefit	$25,000	$25,000*

* The Accelerated Death Benefit amount elected will be reduced by an administrative fee of $100 and interest of 12 months.

5. **Limitations -** We will not pay an accelerated death benefit under this Rider for any Terminal Illness that is diagnosed for the ***first*** time, prior to the Rider Effective Date.

   We will pay an accelerated death benefit only once. If you ask for less than the maximum amount available when you submit a claim, you cannot ask us at a later time to give you the difference between what you did ask for and what you could have asked for.

ACKNOWLEDGMENT

I acknowledge that I have read this disclosure and understand that if I exercise the Accelerated Death Benefit option, any Beneficiary I designate may receive a reduced Death Benefit.

Date	Owner's Signature

Please return a signed copy to our Administrative Office address shown at the top of this form

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Administrative Office: PO Box 869094 Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

WAIVER OF PREMIUM DUE TO LAYOFF OR STRIKE RIDER

This Rider is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail. This Rider has no cash value.

DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

Layoff - The Owner has been employed on a full-time basis at the time of the Layoff and is involuntarily terminated by his or her employer due to one of the following reasons.

1. A reduction in work force as the result of economic conditions;
2. The employer's decrease in production; or
3. The employer's reorganization causing the discontinuation of the Owner's job or resulting in a change of aptitude or skill requirements of his or her job.

Strike – A work stoppage at the Owner's place of employment that is supported and/or sponsored by the state or national union headquarters.

BENEFITS

We will waive the monthly premiums on the contract if the Owner is placed on Layoff status or is on Strike, provided that the first premium on the contract to which this rider is attached has be paid. Monthly premiums will begin being waived the first day of the month following the date of Layoff or Strike.

LIMITATIONS AND EXCLUSIONS

We will waive premiums for up to 3 Layoffs or Strikes in any one 12-month period.
We will wave premiums for up to 6 months in any one 12-month period.
A 12-month period will be measured from the date the first premium is waived.

If the Portability Option provision of the contract has been exercised, if any, the Owner will need to provide proof of being employed (other than self-employment) for the 6 months prior to the Layoff or Strike.

This Rider is not available for self-employed individuals.

PREMIUM

The premium for this Rider is shown on the Certificate Schedule.

EFFECTIVE DATE

The Rider Effective Date is the same date as the contract Effective Date, unless we inform the Owner in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of:

1. The date the contract terminates;
2. The date the Rider or contract Lapses for failure to pay premium, subject to the Grace Period of the contract;
3. The date the Owner requests termination;
4. The date the Owner dies;
5. The Certificate Anniversary Date on or following the Insured's 65th birthday; or
6. The date the Owner assigns the contract to another individual.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

General Counsel and Secretary

President

COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS

Agents who sell and service our products are paid a commission. It varies by the type of insurance policy sold and the state where the policy was sold, and is based on a percentage of the premium received in the first year, and at policy renewal. Agents may receive advances or loans against anticipated commissions for cases sold or to be sold. These advances may or may not require the payment of interest, depending upon the agent's total business and historical experience with TEB.

Agents may receive other compensation from TEB in the form of cash or non-cash awards or prizes, based upon a variety of factors that may include the level of premium written or earned, persistency and growth of premium, or other performance measures. Agents who manage, supervise or recruit other agents or wholesale our products and services to other agents, may receive commission overrides on business that results from their efforts.

Some of our agents may receive additional payments for providing services in connection with the administration of our products. Fees for such services may be calculated on a per policy or per certificate basis or upon the premium volume associated with a specific case. TEB may additionally reimburse these agents/administrators for certain expenses, such as the cost of mailings.

Agents may occasionally obtain exclusive rights to market TEB products or services to agents, employers, employees or members of associations or unions. Certain groups or associations may also agree to endorse TEB's products to their members. TEB may pay a fee for these exclusive marketing rights or endorsements. See your proposed plan documents or policy certificate package for more information on any such arrangements.

For up to date information regarding our compensation practices, please consult our website at: www.transamericaemployeebenefits.com.

Client Vision Care Plan

Client Name: **FOREST RIVER, INC.**
Client Number: **30068748**
Effective Date: **JANUARY 1, 2021**

EVIDENCE OF COVERAGE

Provided by:

VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided.

HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within [365] calendar days from the date services are rendered and/or materials provided. Claims received by VSP after [365] days will be denied unless prohibited by applicable state or federal law.

TO OBTAIN FURTHER INFORMATION

Questions regarding your policy or coverage should be directed to:

VSP
1-800-877-7195
or www.vsp.com.

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits and/or Additional Benefit Rider (when purchased by Client) for details.

COORDINATION OF BENEFITS

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

URGENT VISION CARE

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP Preferred Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to VSP at P. O. Box 2350, Rancho Cordova, CA 95741 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

CLAIM PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: Additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], a Covered Person has the right to bring a civil action.

Time of Action: No action in law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy.

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER	The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.
ASSIGNMENT OF BENEFITS	A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.
CLIENT	An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.
COORDINATION OF BENEFITS	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
COPAYMENTS	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
PLAN OR PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).
OPEN ACCESS PROVIDER	Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN ADMINISTRATOR	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
POLICY	The contract between VSP and Client upon which this Plan is based.
SCHEDULE OF BENEFITS	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
VSP PREFERRED PROVIDER	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.
URGENT CARE	Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of $20.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Standard Progressive Lenses covered in full

LENS OPTIONS

Scratch coating covered in full once every 12 months. **
Polycarbonate Lenses covered in full once every 12 months. **
UV (ultraviolet) protected covered in full once every 12 months. **

FRAMES - Covered up to the Plan allowance* once every 24 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $130.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a maximum $45.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

There shall be a Copayment of $20.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $ 30.00* once every 12 months**

Bifocal Up to $ 50.00* once every 12 months**

Trifocal Up to $ 65.00* once every 12 months**

Lenticular Up to $100.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 24 months**

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

NECESSARY
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT C

VISION SERVICE PLAN INSURANCE COMPANY
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Plus Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the Policy or Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Policy, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PROGRAM DESCRIPTION

The Diabetic Eyecare Program (“DEP”) is intended to be a supplement to Covered Person’s group medical plan. Providers will first submit a claim to Covered Person’s group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as “Coordination of Benefits” or “COB." Please refer to the Coordination of Benefits section of Covered Person’s Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- tunnel vision
- trouble focusing
- “floating” spots
- visual distortion

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- rubeosis
- diabetic macular edema
- age-related macular degeneration
- glaucoma

PROCEDURES FOR OBTAINING DIABETIC EYECARE PLUS SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The DEP Plus Program provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the DEP Plus Program provides Plan Benefits as follows:

1. Covered Person contacts a VSP Preferred Doctor and makes an appointment.

2. Covered Person pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Person's Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP PREFERRED PROVIDER

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Persons upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
2. Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services and/or supplies.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

DIABETIC EYECARE PLUS PROGRAM DEFINITIONS

AMD	Age-related macular degeneration (AMD) is a disease that destroys the clear, “straight ahead” central vision necessary for reading, driving, identifying faces and performing other daily tasks.
Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.
Glaucoma	A disease in which damage to the optic nerve leads to progressive, irreversible vision loss.
Special Ophthalmological Services	Medical eyecare procedures for the investigation and management of ocular disorders associated with diabetic eye disease, glaucoma and/or AMD.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: **FOREST RIVER, INC.**
Group ID: **30068748**
Effective Date: **JANUARY 1, 2021**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$20.00 Copay	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $20.00 Copay (lenses and/or frames only); Up to $45.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 50.00 Tri-Focal Lenses reimbursed up to $ 65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first day of the Benefit Period.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Paramount Dental Plan

Forest River In Network area
Group Number 379280325020

Certificate of Coverage

PARAMOUNT DENTAL
Affiliate of ProMedica

Insurance products are marketed by Paramount Dental and underwritten and administered by Health Resources Inc.

This Handbook along with your Summary of Dental Plan Benefits, describes the specific benefits of your Paramount Dental Plan and how to use them.

Visit Paramount Dental Online 24 hours a day/7 days a week at InsuringSmiles.com

Contact Member Services
Paramount Dental
7:00 am – 7:00 pm CST Monday through Friday 800.727.1444
P.O. Box 659, Evansville, IN 47704-0659

DENTAL PLAN HANDBOOK & CERTIFICATE OF INSURANCE

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY

Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary of Dental Plan Benefits conflicts with a statement in this Certificate, the statement in the Summary of Dental Plan Benefits applies to this plan and you should ignore the conflicting statement in this Certificate.

Language Assistance

English	ATTENTION: If you speak English, free language assistance services are available. Call 1-800-727-1444 (TTY: 711).
Español Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-727-1444 (TTY: 711).
繁體中文 Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-727-1444 (TTY 711）。
Tiếng Việt Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-727-1444 (TTY: 711).
Tagalog Tagalog - Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-727-1444 (TTY: 711).
한국어 Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-727-1444 (TTY: 711) 번으로 전화해 주십시오.
العربية Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1444 -727-800-1 (رقم هاتف الصم والبكم: 711)
Յայերեն Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-727-1444 (TTY (հեռատիպ)՝ 711):
Русский Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-727-1444 (телетайп: 711).
日本語 Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-727-1444（TTY: 711）まで、お電話にてご連絡ください。
فارسی Farsi	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-727-1444 (TTY: 711) تماس بگیرید.
ਪੰਜਾਬੀ **Panjabi**	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-727-1444 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
ខ្មែរ Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-727-1444 (TTY: 711)។
Hmoob Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-727-1444 (TTY: 711).
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-727-1444 (TTY: 711) पर कॉल करें।
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-727-1444 (TTY: 711).
ภาษาไทย Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-727-1444 (TTY: 711).
Deitsch Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-727-1444 (TTY: 711).
ܣܘܪܝܝܐ Syriac	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܡܫܬܡܫܝܬܘܢ ܒܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-800-727-1444 (TTY: 711)
Français **French**	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-727-1444 (ATS : 711).
Italiano **Italian**	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-727-1444 (TTY: 711).

Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

Paramount complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Paramount does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Paramount provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Paramount Member Services at 1-800-727-1444, for TTY users, 711, 7:00 a.m. to 7:00 p.m. CST, Monday through Friday.

If you believe that Paramount has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by phone, mail, fax, or email.

Paramount Dental
1449 Kimber Lane
Ste 103
Evansville, IN 47715

Phone: 1-800-727-1444
TTY: 711
Fax: 812-401-3609
Email: Claims@InsuringSmiles.com

If you need help filing a grievance, Member Services is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW
Room 509F, HHH Building Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Welcome to Your Paramount Dental Plan

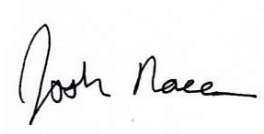
Thank you for enrolling in Paramount Dental! Oral health is a vital part of overall health, and it is our pleasure to be included in your wellness culture. Paramount Dental collaborates with the dental profession to design dental plans that promote oral health care along the most cost effective path. As any dental care professional will attest, the key to avoiding costly dental problems is prevention which starts with you and utilizing the preventive benefits included in your plan. We recommend making your first appointment as soon as possible to ensure you are on the road to great oral health!

You have a wide choice of Network Dentists, both generalists and specialists, nationwide! Network Dentists submit claim forms for services performed for you and payments are paid directly to them. Network Dentists also sign contracts with Paramount Dental to accept certain agreed upon fees, therefore, you and your employer may realize significant savings.

Paramount Dental is also committed to providing the highest quality member services to all Members. Our dedicated team members are available toll-free, Monday through Friday. You may also access information through our website, InsuringSmiles.com. It is your responsibility to be informed about Your Benefits and any associated Limitations and Restrictions, so please read and save this booklet for reference.

Our mission is to offer dental plans that "Improve Your Health and Well-Being". Since 1986, that is exactly what we have delivered to Our Members. We look forward to continuing that promise to our customers.

Sincerely,



Joshua Nace
President - Paramount Dental

This Certificate of Coverage (referred to herein as Certificate) is part of the Master Group Policy that is a legal document (a contract) between Paramount Dental and the Employer. (Referred to herein as We, Us, Our, Paramount Dental, or the Company) and Your Employer Group (referred to herein as Employer) to provide Benefits to Eligible Members (referred to herein as you or your) and is subject to the terms, conditions, Limitations and Exclusions of the Policy. Reasonable effort has been made for this Certificate to represent the intent of the Master Group Policy language between Paramount Dental and Your employer.

Paramount Dental issues this Certificate based on Your Employer Group's Master Group Policy and payment of the required Policy charges. In addition to this Certificate, the Policy includes:

- The Master Group Policy
- Employer Application
- The Summary of Dental Plan Benefits
- Riders
- Amendments

Definitions

Adverse Determination
Any denial, reduction or termination, or a failure to provide or to make payment (in whole or part) of the benefit sought.

Balance Billing
Network Dentists agree to accept the network's contracted fees as payment in full. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as "balance billing" and is not enforceable for Out-Of-Network Dentist as they are under no obligation to limit their fees.

Benefits
The amounts that the Plan pays for Covered Services under a Member's dental Plan. Benefits may be available whether through teledentistry or face-to-face with your Dentist.

Benefit Plan Year
The plan year, unless your employer or organization elects a different period to serve as the Benefit Year.
(See the Summary of Dental Plan Benefits for your Benefit Year.)

Children or Child
Your natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with you during the waiting period for adoption or legal guardianship.

Claim/Claim Form
Standard statement of dental services performed that is submitted by a Dentist or Member to request payment from the Payor. Network dentists always file claim forms on behalf of members and accept payment directly from the Payor. Claim forms are also used to request a pretreatment estimate.

Completion Dates
The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;

- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment / Coinsurance
The Member's share, expressed as a fixed percentage, of the covered dental service.

Coordination of Benefits (COB)
A process that carriers use to determine the order of payment and amount each carrier will pay when a person receives dental services that are covered by more than one benefit plan. COB ensures that no more than 100 percent of the lowest allowable charges for services are paid when a member has coverage under two or more benefits plans (dual coverage) – for example, a child who is covered by both parents' plans.

Covered Services
Dental care services for which a reimbursement is available under a Member's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Custodial Parent
The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the plan year excluding any temporary visitation.

Deductible
The amount a person and/or a family must pay toward Covered Services before Paramount Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Deny/Denied
If a service is denied, the service is not considered a benefit of the patient's coverage and the allowable amount is collectible from the patient.

Dentist
Dental care provider who is skilled in and licensed to practice the prevention, diagnosis, and treatment of diseases, injuries, and malformations of the teeth, jaws, and mouth and who makes and inserts false teeth.

Dependent/Dependent Child
Any Member of a Subscriber's family who meets all the applicable Eligibility requirements, has been enrolled in the plan and for whom the payment required by the employer's group agreement has been received by Paramount Dental.

Dependent Child may include the enrolled employee's biological child, stepchildren, adopted children placed with the enrolled employee whether or not the adoption is final, foster children, children subject to legal court or administrative order to provide health coverage.

Dependent Child also includes any child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. We reserve the right to require proof of incapacity, but not more than annually following the two year period after the child attains limiting age.

Disallow(ed)
If a service is disallowed, the fee is not collectible from the patient by a Network Dentist or the plan.

Effective Date
The date a dental benefits policy begins. Effective date may also be used to describe the date that benefits begin for a Member. The Effective Date is determined in accordance with waiting periods and employment terms enforced by the employer group and applicable State and Federal regulatory entities.

Eligibility
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer.

Eligible Persons –
(Employees + Spouses + Dependents)
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer. Generally, Eligible persons typically include your legal spouses and dependents.

Paramount Dental will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. Dependent children are subject to the employer group's dependent age limitation, which must be no less than age 26.

Dependent child may include the Enrolled Employee's biological children, stepchildren, adopted children, foster children, children subject to legal guardianship, newborn children, or any child for whom the Member is the legal guardian or is required by a court or administrative order to provide health coverage. Coverage for adopted children is effective upon the earlier of: the date of placement or the date of entry of an order granting custody.

Exclusions
Services that are not covered under the Employer Group Dental Insurance Plan.

Explanation of Benefits (EOB)
The statement received after a claim is processed, detailing how Your claim was processed, including

identification of services rendered, fees, application of plan Limitations, calculation of Plan payment, and the amount for which you are responsible.

Fee Charged
The amount that the Dentist bills and is entered on a claim as the charge for a specific service.

Handbook
This document. Paramount Dental will provide Benefits as described in this Handbook. It also serves as your Certificate of Coverage. Any changes in this Handbook will be based on changes to the contract, including the Summary Plan Dental Benefits, between Paramount Dental and your employer or organization.

Lifetime Maximum
The cumulative dollar amount that a plan will pay for dental care incurred by an individual Member for the life of the Member. Lifetime maximums usually apply to specific services such as orthodontic treatment.

Limitations
A list of conditions or circumstances that limit or exclude services from Plan coverage.

Limitations may be related to time or frequency (the number of services permitted during a stated period).

Master Group Policy
The written, legally binding agreement between Paramount Dental and an Employer Group.

Maximum Allowable Amount
The maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meets our definitions of a Covered Service. The maximum allowable/expense is determined by a) the lesser fee of the primary or secondary insurance carrier as it applies to network participation, associated agreed discounts and patient responsibility or b) the fee considered for the global service. For network Dentists, this is the dollar amount that the attending Dentist has agreed to accept as payment in full for the plan and the patient. This amount is shown on the notice that accompanies payment of the claim.

Maximum Allowable Fee
The Maximum Allowable fee amount is the maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meet our definitions of a Covered Service. For Network participating Dentists, the Maximum Allowed Amount will be reimbursed according to a Schedule of Maximum Allowable Charges. Unless specified within the Summary of Dental Plan Benefits of this Policy, the Maximum Allowed Amount for Out-Of-Network Dentists will be reimbursed according to a Table of Allowances as specified in your Summary of Plan Benefits. Paramount Dental's portion of payment for each covered service is the lesser of the Dentist's fee or the maximum allowable fee, minus the co-insurance.

Plan Annual Maximum Benefit
The total maximum dollar amount the Employer Group Paramount Dental Plan will pay toward the cost of dental care incurred by an individual Member in a Plan Year.

Member
A person covered under the Employer Group Paramount Dental Plan. There are two subsets of Members: The Primary Member who is the Employer Group Member under whom the family is enrolled, and the enrolled family members including spouse, domestic partner and eligible children.

Network Dentist
A dentist who contracts with Paramount Dental or leased network carrier and agrees to accept contracted fees as payment in full and abide by certain administrative guidelines.

Network
A panel of Dentists that contractually agree to provide treatment according to administrative guidelines, including limits to the fees accepted as payment in full.

Open Enrollment Period
A period (usually a two-week or one-month period during the year) when qualified individuals (eligible employees) can enroll in or change their choice of coverage in-group benefits plans.

Out of Network Dentist
A dentist who does not contract with Paramount Dental to participate in the network and the associated administrative guidelines including claim submission requirements and maximum allowable fee capitations.

Patient Responsibility
The portion of a Dentist's fee that a Member must pay for dental services, including deductible, coinsurance, any amount over plan maximums, services the plan does not cover and covered services for which the patient is not eligible.

Plan Administrator
The Employer/Sponsor of the Plan or such third party hired by the Employer/Sponsor who performs certain activities for the Plan.

Pre-Authorization
A requirement that recommended treatment must first be approved by the Plan before the treatment is rendered in order for the Plan to pay benefits for those Covered Services.

Premiums

The money billed and paid to Paramount Dental for each month of dental coverage. Payment must be made by an Employer group in order for claims to be paid.

Pre-Treatment Estimate
A non-binding estimate of the benefits available and patient responsibility for a proposed treatment plan after the application of Plan Limitations, restrictions, and exclusions, remaining plan annual maximum and determination of Covered Services.

Qualifying Event
Change in marital status, change in the number of dependents, or change in employment status.

Resin/Composite
Tooth-colored filling material. Although cosmetically superior, it is less durable than other materials.

Submitted/Billed Amount
The amount a Dentist bills to Paramount Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the amount Paramount Dental approves for the treatment.

Subscriber
You, when your employer or organization notifies Paramount Dental that you are eligible to receive Benefits under This Plan.

Summary of Dental Plan Benefits
A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

Waiting Period for Plan Eligibility and For Covered Services
Waiting periods are designated by an Employer Group. If an Employer Group establishes a plan-waiting period, it is the stated period of time that a Member must be enrolled in the Plan before being eligible for benefits or for a specific category of benefits. A waiting period limits reimbursement for various services until the insured has been covered for a specific amount of time. Waiting period can apply to specific/individual procedures as well as at the group level.

Eligibility

Paramount Dental is available through employers for their employees. Your Employer selected the Plan and the level of coverage available for You and Your dependents. Coverage provided under the Plan for Employees and their Dependents shall be in accordance with their Eligibility, Effective Date, and Termination provisions of the Plan, including any coverage classifications. For more information, please contact Your Benefits Administrator.

Paramount Dental. Will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight.

Qualified Medical Child Support Order (QMCSO)
Under certain circumstances, You might be required to provide coverage for a child even if You do not have custody, or if the child is not Your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMSCO). An Employee who is ordered by a QMSCO to provide dental coverage for a child may enroll himself and such child under the Plan. If Your spouse also has dental insurance, he/she may enroll under your plan but special rules apply (see Coordination of Benefits).

Extended Coverage for a Dependent Child
Paramount Dental will acknowledge each individual Employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. If You have dependent(s) with a permanent physical disability or mental disability to the extent they cannot support themselves, they may qualify for coverage beyond the applicable age limit for dependent(s). In order to extend coverage, You must provide Us with proof of the child's incapacity and dependency within 120 days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the 2 year period following the child's attainment of the limiting age.

To request special enrollment or obtain more information, contact your Benefits Administrator or Paramount Dental member services.

Enrollment Periods

Initial Enrollment
At the time You enroll, You are given a coverage Effective Date. Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. You must notify Your employer if You have a change of marital status or other Qualifying Event relating to You or Your dependents within thirty (30) days from the time the Qualifying Event occurs. Otherwise, changes may be made only at Open Enrollment or Plan renewal.

Open Enrollment
Open Enrollment is designated by the Employer and is usually the thirty (30) day period immediately preceding the renewal date of Your Employer's policy with Paramount Dental. During this period, You may drop Your coverage or change dependent coverage. Any changes will be effective on the renewal date of Your Paramount Dental Plan.

Special Enrollment
Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. A special enrollment period can occur if an Eligible Employee or Dependent(s) loses coverage under another health plan. A special enrollment period may also begin when Dependent (s) become newly eligible due to marriage, birth, court order, adoption or placement of a child in the home of the Eligible Employee.

The Eligible Employee must request enrollment within 30 days of the Qualifying Event date. During the Special Enrollment Period, the Employee may enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also enroll any newly eligible Dependent(s) of the Employee under the Plan.

Web Services

Paramount Dental offers information and various services on its website. The website is continually revised, improved and enhanced for Your convenience. Members may:

- Find a Network Dentist,
- Verify benefit plan, renewal dates, dependent coverage, Claim status,
- Print Member Cards,
- Review benefit history,
- Download brochures and Certificates, and
- Acquire oral health and wellness tips.

Online materials serve as the primary source of information for groups, Members, dentists and advisers. Any printed documents that you may have is based on information at a certain point in time and may not be inclusive of all benefits, restrictions and limitations. All documents may also be requested by contacting our Customer Service Center at: 1-800-727-1444.

Member ID Card

A Paramount Dental Member ID Card will be issued to you upon enrollment.

Selecting a Dentist – Receiving Dental Care

Dentistry is a highly personal service. You may have any dental treatment performed as decided by You and Your dentist. Your Dental Plan does not dictate what treatment You receive. Only You and Your dentist can determine that. However, Your Plan does determine what services are covered and by what type of dentist (In-Network vs. Out-of-Network). The coverage selected by Your Employer pays for only those Covered Services under Your Paramount Dental Plan listed in this certificate and Summary of Dental Benefits within the Limitations and restrictions presented. You must personally pay for any service which is not covered or for any service that is covered but is subject to Limitations and restrictions. Your Claim will only be processed after completion of the dental service. If You are not sure whether a particular dental treatment is covered or how much You will be required to pay, You may request a Pre-Treatment Estimate from Your dentist. It is a free service offered by Paramount Dental and highly encouraged so you are never surprised about your dental coverage.

Some services are limited by the age of the patient, by how often the service may be performed, or by specific teeth. All time intervals (frequency limitations) required by coverage are independent of calendar year or plan year. Frequency limitations regarding how often services may be performed are continuous. Change of dental plan coverage, termination and reinstatement of coverage does not eliminate the frequency limitations.

Paramount Dental also offers a large, nationwide, network of credentialed dentists to accommodate oral health needs of You and Your family. Simply visit the Find a Dentist link on InsuringSmiles.com, to view a complete listing of general and specialty Network Dentists in Your geographical area. The Network listing generated from the website includes access to all Paramount Dental and leased Networks included in your Plan offered by your Employer that is outlined your Summary of Dental Benefits. Network Dentists provide the same excellent service at a contracted fee, resulting in savings for You and Your family.

You should always verify the plan and your Summary of Dental Plan Benefits selected by Your Employer prior to Your dental visit as it makes a difference in Your coinsurance and savings. Network Dentists are independent contractors and are not Paramount Dental employees.

Benefit Categories – What is Covered by My Plan?

Important - It is very important to understand that your employer will select which plan services are included in your plan. Please review both this Certificate and the Summary of

Dental Plan Benefits carefully. **ONLY the dental services listed in your Summary of Dental Plan Benefits will be covered by your plan.** The Summary of Dental Plan Benefits is part of this Certificate and supersedes any provision of this Certificate. Covered services are also subject to exclusions and limitations and are included in a later section of this certificate.

The various dental services provided by a dentist are classified into the following categories:

1. Diagnostic and Preventative
2. Restorative
3. Endodontic
4. Periodontics
5. Prosthodontics (removable and fixed)
6. Oral Surgery
7. Orthodontics
8. Adjunctive

Diagnostic and Preventive Services

These services are important to your overall oral health and the detection and prevention of dental disease. They include examinations and evaluations (routine and problem focused), prophylaxes (routine teeth cleanings), radiographs (x-rays), fluoride treatments, and sealants and space maintainers (for children).

Restorative Services

- Minor Restorative Services – these procedures rebuild and repair your teeth damaged by disease, decay, fracture or injury. Both amalgam (silver) and composite (white tooth colored) fillings on baby and adult teeth and anterior and posterior teeth are considered in this category.
- Major Restorative Services – these services include crowns and crown related services. Crowns may be covering a natural tooth or an implant.

Endodontic Services

These procedures treat teeth with diseased or damaged nerves. Root canals are included in this category.

Periodontic Services

- **Non-surgical Periodontics Services** – these procedures involve the treatment of diseases of the gums and supporting structures of the teeth. Nonsurgical procedures include periodontal scaling and root planning, full mouth debridement and periodontal maintenance following a periodontal therapy (periodontal cleanings).
- Surgical Periodontal Services – procedures that related to surgery of your gums which can include osseous surgery and gingivectomy.

Prosthodontic Services (fixed and removable)

- Bridges, partial and complete dentures are in this category.
- Relines and Repairs – these procedures reline and repair existing dentures (partial and complete) and repair existing bridges.
- Implant Services – the placement of an endosteal implant and the associated abutment.

Oral Surgery

- Simple Extractions – this procedure is an extraction of a tooth that is erupted or exposed root.
- Surgical extractions of tooth/teeth are included in this category and include the removal of impacted teeth and other extractions including removal of bone. An incisional biopsy of oral tissue for the detection of cancer or other suspected disease is also included in oral surgery services.

Adjunctive/Other Services

Your Summary of Dental Plan Benefits will list any other benefits that may have been selected.

Orthodontic Services

A “Rider” to your Plan must be selected and included in your Summary of Dental Plan Benefits to have Orthodontic Services covered. Orthodontic covers traditional braces, clear orthodontic treatment (Invisalign) and removable appliances. Retainers are considered part of the orthodontic treatment.

How Payment is Made for These Benefits Categories

When filing claims, your dental office will use the appropriate dental code(s) found in the American Dental Association’s current CDT Code Book. The codes are too numerous to list, however the staff at your dental office is well versed in using these codes and the staff can explain them more thoroughly at your request.

It is best, though not necessary, to have your dentist file a pretreatment estimate for services totaling over $300 to fully identify what benefits are available to you. This will avoid any confusion as to the balance you may owe your dentist. Not all plans cover the same procedures, and if there is any doubt to the coverage of your plan a representative of Paramount Dental would be glad to go over it with you. Your dentist also has access to your specific coverage and can review it with you.

Coinsurance

Covered Services and the percentage of covered expense provided by the Plan and limitations to covered services are indicated on Summary of Dental Plan Benefits. The percentage of plan payment (coinsurance) is valid only for services obtained from participating network Dentists contracted with Paramount Dental or a leased network. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as

"balance billing" and is not enforceable for Out-of-network Dentists as they are under no obligation to limit their fees.

Plan Features

This list of plan features describes the features that are available through Paramount Dental but may not be included in the coverage that you or your employer has selected. To see a list of plan features that are specific to your benefit coverage, please refer directly to Summary of Dental Plan Benefits. If a plan feature is not listed on your Summary of Dental Plan Benefits then it is not a part of your Dental Benefit Plan.

Plan Annual Maximum Benefits/Plan Year

Benefits payable under the Plan, regardless of whether coverage is continuous or not, shall be subject to the Plan Annual Maximum for each plan year. Payments under your Certificate for ALL Covered Services apply to the Plan Annual Maximum benefit excluding orthodontic services. Change of the dental plan coverage, termination, and reinstatement of coverage does not eliminate frequency limitations or Plan Annual Maximum benefit used.

Annual maximum benefits are based on a policy/benefit year unless otherwise noted on the Summary of Dental Plan Benefits beginning with the Plan's effective date of coverage,

After the Plan Annual Maximum Benefit is exhausted, you are responsible for all subsequent charges to your dentist.

Lifetime Maximum Benefit – Orthodontics

If your plan includes orthodontics coverage, your Summary of Dental Benefits will list a lifetime maximum of orthodontic benefits per member. This is the cumulative dollar amount that will be paid for orthodontic dental care for the life of the Member.

Deductible

The Plan Year Deductible (if any) is applicable to Covered Services incurred in each Plan Year. Your policy will determine the Deductible application method chosen by Your employer. The available methods include:

Out of Pocket Deductible-

An out of pocket deductible is the specified & consistent amount reduced from the plan's covered expense which must be paid in full by the Member each plan year. It is applied chronologically according to the dates in which the Covered Services were completed and increases the patient responsibility by the specified amount until the earlier of two events 1) individual deductible is met, or 2) family deductible is satisfied.

Ex: (Fee Allowed X Co-Insurance) – Deductible = Plan Payment

Patient A receives major services covered at 50% under the plan. This patient is responsible for a $50 individual deductible.

Benefit Deductible

A benefit deductible is the amount a Member must pay toward Covered Services before the carrier will reimburse for those Covered Services. This amount may vary based upon the co-insurance of the Covered Service.

Ex: (Fee Allowed – Deductible) X Co-Insurance = Plan Payment
Patient B receives major services covered at 50% under the plan. This patient is responsible for a $25 individual deductible.

Waiting Period

The Waiting Period is the period of time beginning on the Member's Effective Date before benefits for certain Covered Service become eligible for reimbursement. Unless otherwise specified, the most recent effective date is utilized in the application of the Waiting Period, this includes a change to Your dental plan coverage such as termination and reinstatement of coverage.

Alternate Benefits

There is often more than one service that can be used to appropriately treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. If applicable, the amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. A Member and his Dentist may decide on a more costly service or material than We have determined to be satisfactory for the treatment of the condition. In this case, the Plan will be a benefit toward the cost of the more expensive service or material, but the payment will be limited to the benefits payable for Covered Expenses for the least costly Covered Service.

Unbundling

When charges for less complicated Services performed in conjunction with the more comprehensive/extensive definitive treatment are separated, these less complicated components may be considered as parts of the primary Service. If the Dentist bills separately for the primary Service and each of its component parts, the total benefit payable for all related charges will be limited to the benefits payable for Covered Expenses for the primary Service.

Service Exclusions

Paramount Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Benefits. All charges for the same will be your responsibility (though your payment obligation may be

satisfied by insurance or some other arrangement for which you are eligible):

General Exclusions
All Master Group Policies and Certificates issued or administered by Paramount Dental are subject to the following General Exclusions.

This plan will not pay for:

1. Dental services that are not listed in the Plan Covered Services and Plan General Exclusions, Limitations and Restrictions attached to this Certificate.
2. Claims for dental services rendered before the Effective Date or after coverage is terminated.
3. Claims for dental services covered under non-dental insurance.
4. Claims for services performed primarily to rebuild occlusion or for full mouth reconstruction.
5. Claims for Enrollees until Paramount Dental receives the appropriate contracted payment(s) for Premiums.
6. Claims for services which are not completed.
7. For duplicates, lost, or stolen prostheses, appliances, and/or radiographic images.
8. A Claim must be received within one year from the date of service.
9. Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous (baby) teeth.
10. Orthodontic treatment, unless otherwise specified in your Summary of Dental Plan Benefits.
11. Treatment of temporomandibular joint or jaw joint disorder (TMJ).
12. Dental services provided by a non-network participating dentist to the extent that the charges exceed the amount payable for services under the nonparticipating dentist fee schedule.
13. Pediatric dental Essential Health Benefits (EHB) as mandated by the Affordable Care Act (ACA).
14. Dental services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
15. Dental services or charges separately billed by hospitals, laboratories, pharmacies or other institutions other than a dentist practice.
16. Experimental or investigational dental treatment.
17. Dental services as a result of your participation in a misdemeanor, felony, riot or insurrection.
18. Dental services charged and filed on a claim under an unspecified CDT service code X999.
19. Submitted claims for which Paramount Dental has not received the dentist documentation (federal W9 form, documentation requirements – radiographs, primary explanation of benefits, etc., or unable to process due to incorrect filing information) required to determine and finalize the claim benefit.

Service Limitations

The benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Paramount Dental plan or, at the request of your group, any dental plan:

Diagnostic Evaluations and Treatments
Evaluations (examinations), including any and all procedure codes, are payable as stated in your Summary of Benefits. These include all examinations and evaluations performed by any general dentist or specialist.

A comprehensive oral evaluation or a comprehensive periodontal evaluation for a new or established patient is payable according to the time period specified in your Summary of Benefits. A comprehensive periodontal evaluation will only be payable for members that are age 14 and above.

Diagnostic Imaging, Tests, and Examinations
The maximum amount considered for all radiographic images (also referred to as X-rays) taken on one day will be equivalent to an allowance of a full mouth X-ray. The difference may not be billed to the Enrollee.

Panoramic (including image capture only) or full mouth X-rays are payable according to your Summary of Benefits. If a full mouth X-ray is performed within 12 months of any bitewing image(s), the allowable amount for the full mouth X-ray will be reduced by the charges for bitewing(s). Panoramic or full mouth X-rays will not be payable if performed within 12 months of a set of vertical bitewings images.

Periapical images (including image capture only) are payable up to a maximum of 3 during a 12-month period.

Occlusal images (including image capture only) are payable only once per arch per 12 months.

Vertical bitewings (including image capture only) are payable once per 12 months unless a complete series of images or four bitewings were paid in that same 12 months.

Bitewing radiographic images (including image capture only) are limited to the amount specified in your Summary of Benefits. Bitewings will not be payable if performed within 12 months of a complete series of images or a set of vertical bitewings images.

2D cephalometric images or 2D oral/facial photographic images (including image capture only) will be payable only if performed in conjunction with a Plan that covers orthodontic services and treatment. Cephalometric images are payable

every 2 years unless image captures only were paid during the same 2 years. 2D oral/facial images are payable every 5 years unless image captures only were paid during the same 5 years.

Pulp vitality tests are payable for one charge per date of service.

Diagnostic casts are payable once per 5 years and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Preventive Services:
Prophylaxis: A teeth cleaning (includes prophylaxis, periodontal scalings and root planning, periodontal full mouth debridement and periodontal maintenance) is payable according to the limitations listed in your Summary of Benefits., regardless of the dentist's specialty. A teeth cleaning for children under the age of 14 will be payable when filed as a child's cleaning.

Fluoride: A preventive fluoride treatment is payable as listed in your Summary of Benefits.

Sealants: Will be payable on permanent molar teeth (per tooth) as listed in your Summary of Benefits. A replacement for a sealant will not be payable for a period of 5 years. If a sealant was applied to a tooth, a restoration on the same tooth will not be payable for a period of 3 years.

Space Maintenance: Space maintainers are payable once every 3 years for children under 13 years of age The re-cementation or re-bonding of a space maintainer is payable only after 12 months after the initial placement and only once per 12 months.

Restorative Services:
A restoration/filling (amalgam or resin-based composite) is payable as listed in your Summary of Benefits. An additional restoration on the same tooth surface will not be payable for a 2-year period. A restoration will not be payable within 2 years of placing a crown on the same tooth or a sealant on the same surface within 2 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered for payment.

Crowns, or Inlays/Onlays (in any combination including implant supported) are payable as listed in your Summary of Benefits. A charge for a crown or an inlay/onlay on a tooth following the placement of an amalgam or resin-based composite restoration on the same tooth is not eligible for payment for a period of 2- years. Crowns, other than prefabricated steel crowns, are not payable for primary teeth. Composite/resin inlays must be laboratory processed.

A resin-based composite (indirect) crown is payable on anterior teeth only.

Individual crowns over implants are payable as listed in your Summary of Benefits.

Not all crowns or inlay/onlays procedure codes are considered covered if a corresponding procedure code using new and advanced materials is determined to be available.

Crowns, inlays/onlays may be subject to review for extensive loss of tooth structure due to caries (decay) or fracture to determine coverage. A pre-treatment estimate is recommended to determine coverage.

A recementation of an inlay, onlay, or crown is payable only once per 12 months and will not be considered for payment if within 12 months of the original cementation.

A protective restoration is payable once every 2 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for a subsequent definitive treatment are subject to an adjustment if performed within 12 months of a protective restoration.

A core buildup will not be payable if performed as specified in your Summary of Benefits. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed. A pre-treatment estimate is recommended to determine coverage.

A pin retention is payable per tooth and limited to posterior teeth only. Additional pins will be disallowed.

A post and core in addition to a crown is payable once per 5 years per tooth. A payment is not eligible if performed within 5 years of a core buildup or another post and core. Procedure is not payable without history of root canal therapy.

Endodontics:
A therapeutic pulpotomy is payable for primary teeth only and only once per tooth per lifetime. Charges are exclusive of the final restoration charge.

All pulpal and endodontic therapy and apexification/recalcification should be coded by the tooth receiving treatment, not the number of canals per tooth. A single periapical will be considered for payment with an endodontic therapy or an apexification/recalcification only (not pulpal). Separate fees for other radiographs and images are considered part of the treatment plan and will be

disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.

Pulpal therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Endodontic therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Apexification/recalcification is limited to children under 16 years of age and once per lifetime. Not eligible for payment for retreatment within 4 years of the date of the original treatment.

An apicoectomy is payable only once per lifetime.

A canal preparation and fitting of preformed dowel or post is payable once per 7 years. Charges will be disallowed if submitted in conjunction with a post and core, fabricated post, or prefabricated post/core.

Non-Surgical and Other Periodontal Services:
Periodontal maintenance is payable as listed in your Summary of Benefits. This procedure will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a scaling in the presence of gingival inflammation, or a full mouth debridement.

A scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable as listed in your Summary of Benefits. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling in the presence of gingival inflammation, a full mouth debridement or periodontal maintenance. The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Not payable on deciduous teeth. This procedure requires the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. Charges not meeting established criteria will be disallowed. A pretreatment estimate is recommended to determine coverage. Dental Review Team maintains discretionary authority regarding review requirements.

A scaling in presence of generalized moderate or severe gingival inflammation – full mouth is payable once every 5 years and only for enrollees over 15 years of age. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a full mouth debridement or periodontal maintenance.

A full mouth debridement is payable only for enrollees over 15 years of age. Procedure is payable once every 3 years and 3 years must lapse between any associated periodontal scalings (scaling and root planning and scaling in the presence of gingival inflammation) were performed. Will not be payable if performed within 6 months of or the same date of service as a prophylaxis, a scaling and root planning or a scaling in the presence of gingival inflammation, or periodontal maintenance.

Periodontic Surgical
The following services are payable only once per area treated within a 5-year period:

- Gingivectomy or gingivoplasty (four or more teeth/tooth per quadrant only)
- Clinical crown lengthening (per tooth)
- Osseous surgery
- Guided tissue regeneration (includes barrier and its removal, as necessary)

Two tissue grafts (of any type, including pedicle soft, autogenous connective, non-autogenous connective, and free soft) are payable once per area treated/quadrant every 5 years. Teeth #24-25 are considered one site.

Prosthodontics:
One upper and one lower denture (including complete, immediate, partial, immediate partial, overdenture and interim) are payable as listed in your Summary of Benefits. Charges for a conventional, removable partial dentures or a complete denture are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch or of any repairs, relines, rebases. Separate charges for diagnostic casts will be disallowed. An immediate denture will not be payable if used to replace a complete denture.

A repair to a complete or partial denture is payable once per 6 months only after 6 months has elapsed since the initial date of delivery of the appliance. A repair to a partial denture that replaces all teeth and acrylic on framework is payable once per 4 years only after 4 years has elapsed since the initial delivery of the appliance

A rebase or reline to a complete or partial denture is payable once per 4 years only after 6 months has elapsed since the initial date of deliver of the appliance.

Two tissue conditioning charges will be payable only within 6 months of delivery of immediate partial/denture only.

Fixed partial dentures, including partial denture pontics (non-resin), partial denture retainers (cast metal and porcelain/ceramic retainers only), and partial denture retainers-crowns (non-resin) are payable as listed in your Summary of Benefits. Charges are subject to the same definitions and restrictions as single restoration crowns. Each unit of a fixed partial denture must be

identified on the claim. Not eligible for pontics to replace third molars. All fixed prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 5 years of the original placement.

A re-cement or re-bond of a fixed partial denture is payable only once per 12 months per fixed partial denture and only after 12 months of the original cementation.

Oral Surgery:
Surgical extraction of an erupted tooth requiring removal on bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated, and the removal of residual tooth roots procedures include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed.

An exposure of an unerupted tooth or the placement of a device to facilitate the eruption of an impacted tooth will be payable only once per lifetime if the procedure is performed in conjunction with a Plan orthodontic covered services and treatment.

An incisional biopsy of soft oral tissue will be disallowed if performed in conjunction with an apicoectomy.

A transseptal fiberotomy/supra crestal fiberotomy is payable only on anterior permanent teeth and bicuspids and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Alveoplasty in conjunction with routine extractions are subject to review. Charges not meeting generally accepted standards of care will be disallowed.

Vestibuloplasty, ridge extension, procedures charges in conjunction with implant services will be disallowed.

Removal of torus mandibularis is payable only once per arch per lifetime.

Incision and drainage of abscess filed in conjunction with definitive treatment will be disallowed.

A frenectomy is payable once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed.

Excision of pericoronal gingiva filed in conjunction with definitive restorative treatment will be disallowed.

Implant Services
A surgical placement of an implant body (endosteal) or a mini implant is payable as listed in your Summary of Benefits. Allowance includes the treatment plan, local anesthetic and post-surgical care. Coverage is limited to enrollees over 15 years of age.

A prefabricated abutment or a custom fabricated abutment is payable once per 5 years per tooth site. Coverage is limited to enrollees over 15 years of age.

Single crowns and fixed partial denture retainers (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported single crowns and fixed partial dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Removable dentures and fixed dentures (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported removable dentures and fixed dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Adjunctive/Other Services Limitations
Palliative (emergency) treatments will be payable 2 per 12-month period. Charges filed in conjunction with definitive treatment will be disallowed.

Deep sedation/general anesthesia and intravenous moderate (conscious) sedation/analgesia will be payable up to a total of 30 minutes per date of service.

Inhalation of nitrous oxide/analgesia will be payable once per date of service.

An athletic mouth guard is payable once per 12 months.

Occlusal guards are payable once every 5 years. Charges to modify the appliance or for occlusal adjustment are not payable.

Teledentistry benefits are payable as specified in your Summary of Benefits.

Disallowed Services

Participating Dentists may not charge eligible persons for disallowed services or supplies. All charges fromnon-participating dentists for the disallowed services areyour responsibility.

How Payment Is Made

In-Network Dentists
In-Network Dentists are responsible for submitting claims to Paramount Dental on Your behalf for rendered services. Paramount Dental will reimburse the In-Network Dentist directly for Covered Services.

A Member is responsible for the Deductible and any out-of-pocket expenses required by the Plan including the co-insurance and the cost of services that are not covered by the Plan. It is possible that Your dentist's charges for one or more of the services may be higher than the maximum allowable under Your Paramount Dental. If so, an In-Network Dentist must reduce the charged amounts. If a Member is billed by an In-Network Dentist for a Covered Service (other than the Deductible, co- insurance, or amount above the maximum allowable fee), the Member should contact either the In-Network Dentist or Paramount Dental.

Out-Of-Network Dentists
If You visit an Out-Of-Network Dentist, you may be personally responsible for submitting claims directly to Paramount Dental. Some Out-Of-Network Dentist will file the claim as a courtesy to their patients, but they are under no obligation to do so. A Member must provide all of the information the Plan needs to process such claims, including an ADA approved claim form, an invoice of the charges and proof of payment. If a Member does not provide this information, a Member may not be paid or the payment will be distributed to the Out-Of-Network Dentist.

A Member is responsible for the Deductible, any out-of-pocket expenses required by the Plan including the coinsurance and the cost of services that are not covered by the Plan, and any charges above the maximum allowable for the service.

Your out-of-pocket expenses will most likely be higher by seeing an out-of-network dentist because your dentist can Balance Bill the amount that is not covered by Paramount Dental to you and you are responsible for all charges not covered by your Dental Plan.

Filing a Claim
Network Dentists are responsible for submitting claims to Paramount Dental on your behalf. Out-Of-Network Dentist may file the claim as a courtesy to their patients, but are under no obligation to do so. All claims should be submitted to the Paramount Dental address provided in a separate section of this document. The following information should be included on a standard ADA claim form:

1. Covered Employee's name, address, and identification number (SSN)
2. Patient's name, date of birth, and identification number (SSN)
3. Itemized bill including the ADA code, description of each charge, and date of service
4. Name and address of the Rendering Dentist
5. Rendering Dentist's Tax ID Number (W-9 Form)

Note: To be considered for payment, a claim must be submitted within 1 year from the date of service. Some services may require additional information, such as a radiograph image or a periodontal chart before being processed. Benefit payment can only be determined at the time that that claim is submitted with all required documentation. Reference the Plan General Exclusions, Limitations, and Restrictions, including provider supporting documentation provision for more information.

Notice of Claim

We must receive written notice within sixty (60) days after a Claim starts or as soon as reasonably possible. Failure to give notice within that time will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give notice at that time, but such notice was given as soon as was reasonably possible. The notice shall be sent to Paramount Dental or given to Our agent. Notice given by or on behalf of the Member or the Member's beneficiary to Us or to any of our authorized agents with information sufficient to identify the Member is considered notice to Us. If You visit an Out-of-Network Dentist, You may personally be responsible for submitting Claims directly to Paramount Dental.

Claim Forms

Your dentist will file Your claim or provide You with the forms necessary to file the claim. If Your dentist does not provide these forms within fifteen (15) days, You may send Us a written statement to satisfy this requirement. This statement should include enough information to identify You as well as the nature and extent of the Claim. It should be sent to Us within the time stated in the Proof of Loss provision.

Once Paramount Dental processes Your dental Claim, You will receive an Explanation of Benefits explaining payment amounts. It is possible that Your dentist's charges for one or more of the procedures may be higher than the maximum allowed under Your Paramount Dental. If so, a contracted Network Dentist must reduce the charged amounts. An Out-of-Network Dentist may charge You for the difference since they are not contractually liable to accept Your plan's fee schedule.

Proof of Loss

We must receive written proof of loss within ninety (90) days of a Claim. If it is not possible for proof to be provided within

the ninety (90) days, We will not deny a Claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless You are legally incapacitated.

Time of Payment of Claims

Benefits for loss covered by the Policy will be paid when Paramount Dental receives all information necessary, including premium payment, to correctly adjudicate the claim, but not more than thirty (30) days after receipt of all necessary information. Upon the Member's death, any payments outstanding will be paid, at our option, to the Member's beneficiary or to the Member's estate.

If We fail to pay or deny a clean claim in the time required, and We subsequently pay the claim, We will pay the provider that submitted the claim interest on the allowable amount of the claim.

Legal Actions

A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Coordination of Benefits

Coordination of Benefits ("COB") applies to this plan when an eligible person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this plan's benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Terms:

1. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    a. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

    b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, which is associated with a Covered Service for which reimbursement is available or for which reimbursement would be available but for the application of contractual limitations. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

4. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the plan year excluding any temporary visitation.

5. Benefit reserve is the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

Order of Benefit Determination Rules:

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
3. Each Plan determines its order of benefits using the first of the following rules that apply:

a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the [calendar] year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(2) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(3) For a Dependent Child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

f. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan:
When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right To Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Paramount Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Paramount Dental need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Paramount Dental any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan or plans, Paramount Dental will have the right, exercisable alone and at its discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision. The amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments; Paramount Dental will be fully discharged from liability under the Plan. The benefits that are payable in accordance with this provision will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this provision.

Right of Recovery
Whenever payments have been made in excess of the amount due under the Plan, the Paramount Dental shall have the right, exercisable alone and in its sole discretion, to recover such excess payments from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

Termination of Coverage

Your dental coverage may be automatically terminated:
When Your employer advises Paramount Dental to terminate Your coverage;

When Your employer fails to pay timely Premium payments or fees to Paramount Dental; or

For any other reason stated in the Policy.

A person whose Eligibility is terminated may not continue coverage under their Employer's contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) or comparable, nonpreempted state law.

Continuation of Coverage

Continuation Coverage Rights Under The Consolidated Omnibus Budget Reconciliation Act Of 1985 (COBRA)

Introduction
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to an Enrolled Employee who would otherwise lose coverage under the Plan. It can also become available to Enrolled Dependents covered under the Plan when they would lose their coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the COBRA Procedures or contact the Plan Administrator. In the event that an individual receives a COBRA election form with incorrect plan information, the Plan will notify the individual of the accurate Plan terms. The election will be in accordance with the accurate Plan benefit, terms, and coverage.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage will be offered to

each person who is a "Qualified Beneficiary." The Enrolled Employee and each Enrolled Dependent could become Qualified Beneficiaries if coverage under the Certificate is lost because of the Qualifying Event. Under the Master Group Policy, Qualified Beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

An Enrolled Employee will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of either the following:

- Hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct by the Enrolled Employee.

An Enrolled Spouse will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of the following:

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

An Enrolled Child will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of any of the following:

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

When is COBRA Coverage Available?

The Master Group Policy will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

Enrolled Employee or Dependent must notify the Plan Administrator within 60 days after the Qualifying Event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children who are Qualified Beneficiaries.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Enrolled Employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the divorce or legal separation of the Enrolled Employee, or an Enrolled Dependent losing eligibility for coverage under the Certificate as a Dependent Child, COBRA continuation coverage lasts up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Enrolled Employee's hours of employment, and the Enrolled Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If an Enrolled Person covered under Your Certificate is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, each Enrolled Person may be entitled to receive up to an additional 11 months of COBRA continuation coverage (while the disability continues), for a total maximum of 29 months.

Second Qualifying Event extension of 18-month period of continuation coverage
If an Enrolled Person experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the Enrolled Spouse and Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator.

Questions concerning Your Certificate, the Master Group Policy or Your COBRA continuation coverage rights should be addressed to Your Plan Administrator or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area (EBSA Regional Office: Cincinnati Regional Office, 1885 Dixie Highway, Ste 210, Ft. Wright, KY 41011-2664, Tel 859.578.4680/Fax 859.578.4688) or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Change In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members.

Questions and Assistance

Questions regarding your policy or coverage should be directed to:
Claims Department Paramount Dental.
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

General Conditions and Additional Information

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan. No failure to enforce any provision of the Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

Entire Contract & Changes

The Policy, including the endorsements, Certificates, Summary of Dental Plan Benefits, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy will be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by You or the Employer, in the absence of fraud, as a representation and not a warranty.

We may amend coverage, limitations to the Covered Services, General Exclusions, Annual Maximum, benefit payments or any other terms of this Certificate or the Master Group Policy upon thirty (30) days written notice to You and Your employer. This Certificate will pay for any Covered Services rendered prior to the Effective Date of the change. If there are any discrepancies as to coverage, limitations to Covered Services, General Exclusions, Annual Maximum or other provisions stated herein and as stated in the Master Group Policy, the provisions of the Master Group Policy will supersede those set forth herein.

Claims Appeal Procedure

Informal Claims Appeal Procedure
Your Paramount Dental plan has been carefully designed to provide You with the maximum amount of covered benefits for Your level of payment/Premium. Since Paramount Dental is always looking for ways to make Our Master Group Policies and Certificates even better, Your suggestions are encouraged. Occasionally, even after You have reviewed the applicable sections of this Certificate pertaining to Your issue at hand, You may have a question. Your questions may involve dentists, Covered Services, the agents who sold and serviced Your Paramount Dental plan, policies, or procedures.

Paramount Dental always notifies You or Your authorized representative of a benefit determination after Your Claim is filed. This notice is made via an Explanation of Benefits (EOB). An adverse benefit determination is any denial, reduction or termination of the benefit for which You filed a Claim, or a failure to provide or to make payment (in whole or in part) of the benefit You sought. This includes a determination based on Eligibility, the administration of Covered Services, Limitations or restrictions, and payment amounts. If You receive notice of an adverse benefit determination, and if You think that Paramount Dental incorrectly denied all or part of Your Claim, You may take the following steps:

First, You or Your dentist should contact Paramount Dental's Member Services team and ask them to check the Claim to make sure it was correctly processed. If You contact Us in writing, please enclose a copy of Your Explanation of Benefits and describe the problem. Paramount Dental provides this opportunity for You to describe problems and submit information that might indicate that Your Claim was improperly denied and allow Paramount Dental to correct this error quickly.

Formal Claims Appeal Procedure
Whether or not You have contacted Paramount Dental informally, as described above, to recheck the initial determination of Your Claim, You or Your authorized representative may submit Your Claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of Your Claim, You must send Your request in writing to the Dental Claims Review Team at Paramount Dental.

You must include Your name and address, the Member's ID number, the reason You believe Your Claim was wrongly denied, and any other information You believe supports Your Claim, including sections of Certificate that support Your appeal. If You would like a record of Your request and proof that is was received by Paramount Dental, You should mail it certified mail, return receipt requested. You or Your authorized representative should seek a review as soon as possible after You receive Your EOB; however, You must file Your appeal within ninety (90) days of the date of which You receive Your notice of the adverse benefit determination You are asking Paramount Dental to review.

The Dental Claims Review Team will make their decision and notify You in writing within 30 days of receiving Your request. Their notice of any adverse determination will: (a) inform You of the specific reasons for the denial; (b) list the pertinent Master Group Policy/Certificate provision on which the denial is based; (c) contain a statement that You are entitled to receive upon request and at no cost, reasonable access to and copies of the documents, records and other information relevant to the decision to deny Your Claim; and (d) contain a statement that You may seek to have Your Claim re-evaluated by the appropriate Department of Insurance in Your state of domicile. You may also have the right to seek to have Your Claim paid by filing a civil action in court.

Notice of Privacy Practices

In compliance with certain applicable laws, the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Paramount Dental has adopted these policies. Paramount Dental acknowledges participants' privacy rights as specified in these laws, and has adopted policies and procedures to ensure Your privacy rights are protected.

This Notice describes how nonpublic personal financial information (NPFI) and protected health information (PHI) about You may be used and disclosed and how You can access this information. In this Notice, We explain how We protect the privacy of Your NPFI and PHI, and how We will allow it to be used and given out (disclosed). We are required to provide You with a copy of this Notice of privacy practices upon request. We must follow the privacy practices described in this Notice while it is in effect.

Our Commitment Regarding Your Confidential Information:
We understand the importance of Your NPFI and PHI (hereafter known as Confidential Information), and follow strict policies (in accordance with state and federal privacy laws) to keep Your information private.

Our Privacy Principles:

- We do not sell customer Confidential Information.
- We do not provide customer Confidential Information to persons or organizations outside Paramount Dental and Our business associates for marketing purposes.
- We contractually require any person or organization providing products or services on Our behalf to protect the confidentiality of information We obtain from You.

We afford prospective and former customers the same protections as existing customers with the respect to the use of Confidential Information. Your privacy is a high priority for Us and it is treated with the highest degree of respect. We collect and use Confidential Information We believe is necessary to administer Our business and to provide You with customer service. We use Confidential Information to underwrite Your policies, process Your Claims, ensure proper billing, and service Your accounts. We share Confidential Information as necessary to handle Your Claims and to protect You against fraud and unauthorized transactions. However, We want to emphasize that We are committed to maintaining the privacy of this information in accordance with law. All individuals with access to Confidential Information about Our customers are required to follow this policy.

Confidential Information Collected:

- Confidential Information includes demographic data that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health, the provision of health care to You, or the payment for that care.
- Confidential Information includes Your name, address, date of birth, marital status, sex, social security number, dental information, and Enrollee information, including information about Your transactions with Us, such as Claim history and Premium payments.
- Information Disclosed:
- We may provide Confidential Information to You in order to supply You with information about Your Benefits, or if You request to inspect Your Confidential Information.
- We may provide Your Confidential Information to health care providers and to Our business associates who request Confidential Information for payment-related activities and for health care operations.
- We may provide Your Confidential Information to someone who has the legal right to act on Your behalf.
- We may provide Confidential Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.
- We may provide Confidential Information without Your written permission for matters in the public interest such as public health and safety activities or averting a serious threat to the health or safety of others.
- We may provide Confidential Information that We collect to third-parties involved in the underwriting, processing, servicing and marketing of Your Paramount Dental insurance products. We will not provide this information to any other third party for purposes other than set forth above unless We have a written agreement that requires such third party to protect the confidentiality of this information or Your written authorization.

- The law or the courts may require Us to provide Confidential Information to persons or agencies involved in regulatory, enforcement, or civil or criminal judicial activities.
- When We provide Your Confidential Information to any third party, We will provide only a limited data set, or if needed, the minimal amount of information that We deem is necessary.
- We do not disclose any Confidential Information about Our customers to anyone except as permitted or required by law.
- We must obtain Your written authorization for any disclosures of Your Confidential Information for purposes other than those listed above, including disclosures of psychotherapy notes or for marketing purposes.
- We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.

Security of Your Confidential Information:

- Access of Your Confidential Information is available from Us only to persons involved in underwriting, processing information, marketing company products, or providing dental care for Your benefit. Access must be granted to those entities to enable them to provide the excellent service You have come to expect from Paramount Dental.
- We maintain physical, electronic, and procedural safeguards that comply with state and federal standards to guard Your Confidential Information.
- If We become aware that an item of Confidential Information may be materially inaccurate, We will make a reasonable effort to confirm its accuracy and correct any error as appropriate.
- If We believe Your Confidential Information has been breached, You will receive a written notification of the suspected breach.

Individual Rights:

- You have a right to learn about the nature and substance of any Confidential Information Paramount Dental has in its files about You. We reserve the right to charge a reasonable cost-based fee for copying and postage.
- You have the right to an accounting of certain disclosures of Your Confidential Information.
- You have the right to request that We place restrictions on the way We use and disclose Your Confidential Information. We will inform You within thirty (30) days of Our decision concerning Your request. We will agree to any request to restrict the disclosure of Your Confidential Information if the disclosure is for carrying out payment or health care operations and You have paid the provider in full out of Your pocket.
- You have a right to inspect Your Confidential Information and request that We amend it in Our files.
- You have a right to obtain a copy of Your Confidential Information that We use or maintain in an electronic health record. We reserve the right to charge a reasonable cost-based fee to provide such information to You or Your specific designee.
- Individual Enrollees who believe that the way we communicate decisions related to payment and Benefits may endanger their Confidential Information may request that We communicate with them using a reasonable alternative means or location.

Duties:

- Paramount Dental is required to abide by the terms of this Notice, and reserves the right to change the terms of this Notice at any time, provided that applicable law permits such changes. These revised practices will apply to Your Confidential Information regardless of when it was created or received. Before We make a material change to Our privacy practices, We will provide You with a revised Notice of Privacy Practices.
- Where multiple state or federal laws protect the privacy of Your Confidential Information, We will follow the requirements that provide the greatest privacy protection.

Further information:

If You need more information about Our privacy policy, or are concerned that We may have violated Your privacy rights, please contact Paramount Dental's Privacy Officer.

You may also submit a written complaint to:
Attn: Region
V, Office of Civil Rights
U.S. Dept. of Health and Human Services 233 N.
Michigan Ave, Ste 240
Chicago, IL 60601
Voice mail: 312.866.2359
Fax: 313.866.1807

We support Your right to protect the privacy of Your Confidential Information. We will not take action against You.

Physical Examinations and Autopsy

We reserve the right, at our own expense, to examine a Member when and as often as may be reasonably required for the determination of a claim. We may request an autopsy in case of death where it is not forbidden by law.

ERISA

As a participant in a Paramount Dental plan, You may be entitled to certain rights and protections under ERISA. You should check with Your employer to determine whether ERISA applies in Your situation. If You are covered by ERISA, then You may:

- Obtain the Plan Administrator's name, address, and telephone number from Your employer.
- Examine (without charge) at the Plan Administrator's office and at certain other locations, all plan documents, including the group insurance contracts, and copies of all documents filed by the Plan Administrator with the Internal Revenue Service such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- Receive a Summary Annual Report (SAR), Summary Plan Description (SPD) and a Summary of Material Modifications (SMM).
- Receive a written explanation if Your Claim for Benefits has been denied. You have the right to request a review of any such denial. If Your Claim is still denied, You may sue for Your Benefits.
- File suit in Federal court if materials You requested aren't received within thirty (30) days (unless the materials weren't sent because of matters beyond the administrator's control), or if You feel Benefits have been improperly denied, or if You have been discriminated against exercising Your rights under ERISA. If You are successful, the court may require the administrator to provide the materials You requested and pay up to $110 a day until You receive them. The court will decide who should pay the court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim frivolous.

First, consult Paramount Dental or Your employer to be certain You thoroughly understand the dental Benefits coverage and Claims procedures. If, after following all procedures, satisfactory resolution has not been reached, You may wish to contact the appropriate state department of Insurance or the United States Department of Labor for assistance. Your exercise of any rights under ERISA will not adversely affect Your employment status or plan benefits.

Grace Period

A grace period of thirty-one (31) days will be allowed for the payment of each Premium due after the first Premium. This coverage will remain in effect during the grace period unless the Employer has given advance written notice of discontinuance of coverage.

Notification to Insureds

Paramount Dental will notify the Employer in writing by mail to the Employer's last known address at least thirty (30) days prior to the Effective Date of the termination of Your insurance, a change in Your Premium, a change in Eligibility or a change in Your Benefits. This notice will also be provided to You, the agent, and the Plan Administrator, if any.

Misstatement of Age

If the age of any individual covered under the Policy has been misstated, all amounts payable under this policy shall be such as the Premium paid would have purchased at the correct age.

Incontestability

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

Conformity with State Statutes

If any provisions of the Plan is contrary to any law to which it is subject, such provision will be amended to conform to the minimum extent necessary to satisfy legal requirements.
Questions regarding your policy or coverage should be directed to:

Paramount Dental
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

If You (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: 1-800-622-4461 / (317) 232-239
Complaints can be filed electronically at www.in.gov/idoi.

Benefit Details

ADA Code	Service Description	In/Out %
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	100/100
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	100/100
D0145	ORAL EVALUATION FOR A PATIENT UNDER 3 YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	100/100
D0150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	100/100
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	100/100
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT NOT POST-OPERATIVE VISIT)	100/100
D0180	COMPREHENSIVE PERIODONTAL EVALUATION-NEW OR ESTABLISHED PATIENT	100/100
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	100/100
D0220	INTRAORAL-PERIAPICAL FIRST RADIOGRAPHIC IMAGE	100/100
D0230	INTRAORAL-PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	100/100
D0240	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE	100/100
D0270	BITEWING-SINGLE RADIOGRAPHIC IMAGE	100/100
D0272	BITEWINGS-TWO RADIOGRAPHIC IMAGES	100/100
D0273	BITEWINGS-THREE RADIOGRAPHIC IMAGES	100/100
D0274	BITEWINGS-FOUR RADIOGRAPHIC IMAGES	100/100

Benefit Details

ADA Code	Service Description	In/Out %
D0277	VERTICAL BITEWINGS-7 TO 8 RADIOGRAPHIC IMAGES	100/100
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	100/100
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES BY REPORT	100/100
D0330	PANORAMIC RADIOGRAPHIC IMAGE	100/100
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE ACQUISITION, MEASUREMENT AND ANALYSIS	100/100
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES OBTAINED INTRAORALLY OR EXTRAORALLY	100/100
D0460	PULP VITALITY TESTS	100/100
D0470	DIAGNOSTIC CASTS	100/100
D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0703	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY – IMAGE CAPTURE ONLY	100/100
D0706	INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0707	INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0708	INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0709	INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY	100/100
D1110	PROPHYLAXIS-ADULT	100/100

Benefit Details

ADA Code	Service Description	In/Out %
D1120	PROPHYLAXIS-CHILD	100/100
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	100/100
D1208	TOPICAL APPLICATION OF FLUORIDE- EXCLUDING VARNISH	100/100
D1351	SEALANT-PER TOOTH (PERMANENT MOLAR TEETH)	100/100
D1510	SPACE MAINTAINER-FIXED, UNILATERAL - PER QUADRANT	100/100
D1516	SPACE MAINTAINER-FIXED-BILATERAL,MAXILLARY	100/100
D1517	SPACE MAINTAINER-FIXED-BILATERAL,MANDIBULAR	100/100
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL - PER QUADRANT	100/100
D1526	SPACE MAINTAINER-REMOVABLE-BILATERAL,MAXILLARY	100/100
D1527	SPACE MAINTAINER-REMOVABLE-BILATERAL,MANDIBULAR	100/100
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY	100/100
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR	100/100
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT	100/100
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT	100/100
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	50/50
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	50/50
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	50/50
D2330	RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR	50/50
D2331	RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR	50/50
D2332	RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR	50/50
D2335	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES (ANTERIOR)	50/50
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR (PRIMARY ONLY)	50/50
D2391	RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR	50/50
D2392	RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR	50/50
D2393	RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR	50/50
D2394	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR	50/50
D2510	INLAY - METALLIC - ONE SURFACE	50/50
D2520	INLAY-METALLIC-TWO SURFACES	50/50
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	50/50
D2542	ONLAY-METALLIC-TWO SURFACES	50/50
D2543	ONLAY-METALLIC-THREE SURFACES	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	50/50
D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	50/50
D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	50/50
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	50/50
D2642	ONLAY-PORCELAIN/CERAMIC-TWO SURFACES	50/50
D2643	ONLAY-PORCELAIN/CERAMIC-THREE SURFACES	50/50
D2644	ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES	50/50
D2650	INLAY - RESIN-BASED COMPOSITE - ONE SURFACE	50/50
D2651	INLAY-RESIN-BASED COMPOSITE-TWO SURFACES	50/50
D2652	INLAY-RESIN-BASED COMPOSITE-THREE OR MORE SURFACES	50/50
D2662	ONLAY - RESIN-BASED COMPOSITE - TWO SURFACES	50/50
D2663	ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES	50/50
D2664	ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES	50/50
D2710	CROWN-RESIN-BASED COMPOSITE (INDIRECT)	50/50
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	50/50
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50/50
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	50/50
D2753	CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D2780	CROWN-3/4 CAST HIGH NOBLE METAL	50/50
D2781	CROWN-3/4 CAST PREDOMINANTLY BASE METAL	50/50
D2782	CROWN-3/4 CAST NOBLE METAL	50/50
D2783	CROWN-3/4 PORCELAIN/CERAMIC	50/50
D2790	CROWN-FULL CAST HIGH NOBLE METAL	50/50
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	50/50
D2792	CROWN-FULL CAST NOBLE METAL	50/50
D2794	CROWN-TITANIUM AND TITANIUM ALLOYS	50/50
D2799	INTERIM CROWN – FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION	50/50
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	50/50
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	50/50
D2920	RE-CEMENT OR RE-BOND CROWN	50/50
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	50/50
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW (PRIMARY TOOTH)	50/50
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN-PRIMARY TOOTH	50/50
D2940	PROTECTIVE RESTORATION	50/50
D2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	50/50
D2951	PIN RETENTION, PER TOOTH, IN ADDITION TO RESTORATION	50/50
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	50/50
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	50/50
D2960	LABIAL VENEER (RESIN LAMINATE) – DIRECT	50/50
D2962	LABIAL VENEER (PORCELAIN LAMINATE) – INDIRECT	50/50
D2971	ADDITIONAL PROCEDURES TO CUSTOMIZE A CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK	50/50
D2975	COPING	50/50
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)-REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	50/50
D3230	PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	50/50
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	50/50
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)	50/50
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	50/50
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	50/50
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR	50/50
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID	50/50
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	50/50
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	50/50
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC)	50/50
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	50/50
D3410	APICOECTOMY-ANTERIOR	50/50
D3421	APICOECTOMY-BICUSPID (FIRST ROOT)	50/50
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	50/50
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	50/50
D3430	RETROGRADE FILLING-PER ROOT	50/50
D3450	ROOT AMPUTATION-PER ROOT	50/50
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D3950	CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST	50/50
D4210	GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	50/50
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	50/50
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	50/50
D4261	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	50/50
D4266	GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE	50/50
D4267	GUIDED TISSUE REGENERATION, NATURAL TEETH – NON-RESORBABLE BARRIER, PER SITE	50/50
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	50/50
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	50/50
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	50/50
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	50/50
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	50/50
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	50/50
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	50/50
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT SURGICAL SITE AND DONOR MATERIAL)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	50/50
D4341	PERIODONTAL SCALING AND ROOT PLANING-FOUR OR MORE TEETH PER QUADRANT (4 TEETH WITH 4+MM POCKETS)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	50/50
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION	50/50
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	50/50
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH	50/50
D4910	PERIODONTAL MAINTENANCE	50/50
D5110	COMPLETE DENTURE-MAXILLARY	50/50
D5120	COMPLETE DENTURE-MANDIBULAR	50/50
D5130	IMMEDIATE DENTURE-MAXILLARY	50/50
D5140	IMMEDIATE DENTURE-MANDIBULAR	50/50
D5211	MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	50/50
D5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	50/50
D5213	MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5214	MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	50/50
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	50/50
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY	50/50
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR	50/50
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	50/50
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	50/50
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)	50/50
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	50/50
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	50/50
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	50/50
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	50/50
D5630	REPAIR OR REPLACE BROKEN CLASP-PER TOOTH	50/50
D5640	REPLACE BROKEN TEETH-PER TOOTH	50/50
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	50/50
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	50/50
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	50/50
D5710	REBASE COMPLETE MAXILLARY DENTURE	50/50
D5711	REBASE COMPLETE MANDIBULAR DENTURE	50/50
D5720	REBASE MAXILLARY PARTIAL DENTURE	50/50
D5721	REBASE MANDIBULAR PARTIAL DENTURE	50/50
D5730	RELINE COMPLETE MAXILLARY DENTURE (DIRECT)	50/50
D5731	RELINE COMPLETE MANDIBULAR DENTURE (DIRECT)	50/50
D5740	RELINE MAXILLARY PARTIAL DENTURE (DIRECT)	50/50
D5741	RELINE MANDIBULAR PARTIAL DENTURE (DIRECT)	50/50
D5750	RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	50/50
D5751	RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	50/50
D5760	RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)	50/50
D5761	RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)	50/50
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	50/50
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5820	INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY	50/50
D5821	INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR	50/50
D5850	TISSUE CONDITIONING, MAXILLARY	50/50
D5851	TISSUE CONDITIONING, MANDIBULAR	50/50
D5863	OVERDENTURE-COMPLETE MAXILLARY	50/50
D5864	OVERDENTURE-PARTIAL MAXILLARY	50/50
D5865	OVERDENTURE-COMPLETE MANDIBULAR	50/50
D5866	OVERDENTURE-PARTIAL MANDIBULAR	50/50
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	50/50
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	50/50
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)	50/50
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	50/50
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	50/50
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)	50/50
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	50/50
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6066	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	50/50
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	50/50
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	50/50
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	50/50
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)	50/50
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	50/50
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	50/50
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL)	50/50
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	50/50
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	50/50
D6076	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	50/50
D6077	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	50/50
D6082	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	50/50
D6083	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS	50/50
D6084	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6086	IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6087	IMPLANT SUPPORTED CROWN - NOBLE ALLOYS	50/50
D6088	IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	50/50
D6092	RE-CEMENT RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	50/50
D6094	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	50/50
D6097	ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6098	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	50/50
D6099	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS	50/50
D6110	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MAXILLARY	50/50
D6111	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MANDIBULAR	50/50
D6112	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY	50/50
D6113	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR	50/50
D6114	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MAXILLARY	50/50
D6115	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MANDIBULAR	50/50
D6116	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY	50/50
D6117	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR	50/50
D6120	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	50/50
D6195	ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6210	PONTIC-CAST HIGH NOBLE METAL	50/50
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL	50/50
D6212	PONTIC-CAST NOBLE METAL	50/50
D6214	PONTIC-TITANIUM AND TITANIUM ALLOYS	50/50
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	50/50
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50/50
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	50/50
D6243	PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6245	PONTIC-PORCELAIN/CERAMIC	50/50
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	50/50
D6548	RETAINER-PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	50/50
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	50/50
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	50/50
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	50/50
D6753	RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	50/50
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	50/50
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	50/50
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	50/50
D6784	RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS	50/50
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	50/50
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	50/50
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	50/50
D6794	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	50/50
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	50/50
D6940	STRESS BREAKER	50/50
D7111	EXTRACTION, CORONAL REMNANTS-DECIDUOUS TOOTH	50/50
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	50/50
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	50/50
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	50/50
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	50/50
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	50/50
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	50/50
D7251	CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY	50/50
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	50/50
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	50/50
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	50/50
D7284	EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS	50/50
D7286	INCISIONAL BIOPSY OF ORAL TISSUE-SOFT	50/50
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	50/50
D7310	ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	50/50
D7311	ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	50/50
D7320	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	50/50
D7321	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	50/50
D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)	50/50
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	50/50
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	50/50
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM	50/50
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM	50/50
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	50/50
D7472	REMOVAL OF TORUS PALATINUS	50/50
D7473	REMOVAL OF TORUS MANDIBULARIS	50/50
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	50/50
D7511	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)	50/50
D7830	MANIPULATION UNDER ANESTHESIA	50/50
D7922	PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN THE HEMOSTASIS OR CLOT STABILIZATION, PER SITE	50/50
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	50/50
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	50/50
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D7971	EXCISION OF PERICORONAL GINGIVA	50/50
D7980	SIALOLITHOTOMY	50/50
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	50/50
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	50/50
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	50/50
D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION	50/50
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	50/50
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	50/50
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	50/50
D8210	REMOVABLE APPLIANCE THERAPY	50/50
D8220	FIXED APPLIANCE THERAPY	50/50
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT	50/50
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	50/50
D9223	DEEP SEDATION/GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT	50/50
D9230	INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS (PER VISIT)	50/50
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT	50/50
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	50/50
D9941	FABRICATION OF ATHLETIC MOUTHGUARD	50/50
D9944	OCCLUSAL GUARD-HARD APPLIANCE, FULL ARCH	50/50
D9945	OCCUSAL GUARD-SOFT APPLIANCE, FULL MOUTH	50/50
D9946	OCCLUSAL GUARD-HARD APPLIANCE,PARTIAL ARCH	50/50
D9973	EXTERNAL BLEACHING-PER TOOTH	50/50
D9974	INTERNAL BLEACHING-PER TOOTH	50/50
D9995	TELEDENTISTRY – SYNCHRONOUS - REAL-TIME ENCOUNTER	100/100

Plan General Exclusions, Limitations and Restrictions

Including provider supporting documentation requirements.

Eligibility is determined by the last date(s) of service and not based on a calendar or plan year. The last date(s) of service are determined by the prior completion date(s) in which the enrollee was eligible to receive benefits. Covered services for which a patient is not eligible, may be billed to the patient. Covered services that are disallowed by the plan, may not be billed to the patient.

ADA Range	Limitations/Exclusions
D0120, D0145, D0160, D0170	Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0140	An evaluation limited to a specific oral health problem or complaint. The use of this procedure code is also appropriate in dental emergencies, trauma, acute infection, etc. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0150, D0180	Eligible only once every 4 years. D0180 applies to age 14 and above. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0210, D0709	A complete series includes bitewings. Eligible only once per 4 years. Not eligible if performed within 4 years of D0330, D0701 or D0709. If D0210 is performed within 12 months of D0270, D0272, D0273, D0274, D0708 the allowable amount for D0210 will be reduced by the charges for D0270, D0272, D0273, D0274, D0708. Not eligible if performed within 12 months of D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0220, D0230, D0707	Eligible for a maximum of 3 during a 12 month period. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0240	Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0706. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0270, D0708	"Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210, D0277 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.

ADA Range	Limitations/Exclusions
D0272, D0273	Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277.
D0274	"Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277.
D0277	Not eligible if performed within 12 months of D0210 or D0274. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0320, D0321	Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0330, D0701	Eligible only once per 4 years. Not eligible if performed within 4 years of D0210, D0701 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0340	Eligible only once per 2 years. Not eligible if performed within 2 years of D0702. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0350, D0703	Eligible only once per 5 years. Not eligible if performed within 4 years of D0703. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0460	Eligible for one charge per date of service.
D0470	Eligible only once per 5 years. It is included in the charges for complete or partial dentures, separate charges are disallowed. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.

ADA Range	Limitations/Exclusions
D0702	Eligible only once per 2 years. Not eligible if performed within 2 years of D0340. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0706	Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0240. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D1110, D1120	Not eligible for more than 2 cleanings per 12 consecutive month period which includes utilization of codes D4341, D4346, D4355, or D4910. Reimbursement for D1120 is limited to enrollees under the age of 14.
D1206	Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Eligible only for children under 14 years of age.
D1208	Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Age limitation may apply.
D1351	Eligible on permanent molar teeth (per tooth) only. Not eligible for replacement for a period of 5 years. Eligible only for children under 15 years of age. Not eligible for a restoration on the O, OB, or OL surfaces following the placement of a sealant on that surface or if a restoration involving the O surfaces has been performed for a period of 3 years.
D1510, D1516, D1517, D1520, D1526, D1527, D1575	Eligible only for children under 13 years of age. Not eligible if performed within 3 years of D1510, D1515, D1520, D1525, or D1575.
D1551, D1552, D1553	Not eligible within 12 months of the initial placement of the space maintainer. Eligible once per 12 months.
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394	Not eligible for the replacement of or an additional restoration on the same surface for a period of 2 years. Not eligible if performed within 3 years of placing a crown on the same tooth or a sealant on the same surface within 3 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered.

ADA Range	Limitations/Exclusions
D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2651, D2652, D2662, D2663, D2664, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2650	Not eligible for a replacement by any type of inlay, onlay, or crown for 7 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2710	Eligible on anterior teeth only. Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2910, D2915, D2920, D6092	Not eligible for the recementation of an inlay, onlay, or crown within 12 months of the original cementation. Eligible once per 12 months.
D2930, D2931, D2933, D2934	Charges are subject to the same restrictions and conditions as D2520 through D2794.
D2940	Not eligible for replacement by another protective restoration for a period of 3 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for definitive treatment are subject to an adjustment if performed within 12 months of D2940.
D2950	Not eligible within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for core buildups requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed.
D2951	Charge is per tooth and limited to posterior teeth only. Additional pins will be disallowed.
D2952, D2954	Not eligible if performed within 7 years of D2950, D2952, or D2954. Eligible once per 7 years per tooth. Not allowable without history of root canal therapy.

ADA Range	Limitations/Exclusions
D2960	Not eligible for a replacement for 3 years. Placement is restricted to anterior permanent teeth only.
D2962	Not eligible for a replacement for 7 years. Placement is restricted to anterior permanent teeth only. Charges for veneered crowns replacing labial veneers (porcelain) are not allowable for 7 years.
D3220	Eligible for primary teeth only and only once per tooth. Charges are exclusive of the final restoration charge.
D3230	Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3240	Eligible on primary posterior teeth only. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3310, D3320, D3330, D3333, D3346, D3347, D3348	Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3351, D3352, D3353	Limited to children under 16 years of age. Eligible once per lifetime. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3410, D3421, D3425, D3426, D3430, D3450, D3920	Eligible once per lifetime.
D3950	Eligible once per 7 years. Charges will be disallowed if submitted in conjunction with D2952, D2953, D2954, or D2957.

ADA Range	Limitations/Exclusions
D4210, D4260, D4261	Eligible only once per area treated for a 5 year period.
D4249	Eligible only once on a per tooth basis. Eligible only once per tooth per lifetime.
D4266, D4267	Charges include the charge for the barrier, and its removal, if necessary. Eligible only once per area treated for a 5 year period.
D4270, D4273, D4275, D4277, D4278	Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. Eligible only once per area treated for a 5 year period.
D4274	Eligible only when this procedure is performed in an edentulous area adjacent to a periodontally involved tooth. The tooth and proximal area must be identified. Eligible only if no additional surgery is performed in the immediate area, eligible every 5 years. Eligible only once per area treated for a 5 year period.
D4283, D4285	Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site.
D4341	Eligible per quadrant (4 or more active periodontal diseased and qualified teeth). The enrollee must exhibit pocket depths of at least 4 mm around at least 4 teeth in each quadrant to qualify for coverage for this procedure. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements.
D4342	Eligible per quadrant (1 to 3 active periodontal diseased and qualified teeth). The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements.
D4346	Eligible only for enrollees over 15 years of age. Eligible once per 5 years. Not eligible within 6 months of or same date of service as D1110, D1120, D4341/D4342 (quadrant allottment may apply), D4355, or D4910.

ADA Range	Limitations/Exclusions
D4355	Eligible only for enrollees over 15 years of age. To be eligible, procedure must be performed before and not on the same date of service as D1110, D4341, D4342, D4346, or D4910, or more than 3 years has lapsed since D1110, D4341, D4342, D4346, D4355, or D4910 was performed.
D4381	Eligible once per 5 years.
D4910	Not eligible if performed within 6 months of or same date of service as D1110, D1120, D4341/D4342 if four quadrants were treated, D4346 or D4355. Not eligible for more than 2 per 12 consecutive month period. Eligible only for enrollees over 15 years of age.
D5110, D5120, D5282, D5283	Not eligible for the replacement of a denture, including an immediate or partial denture, within 7 years. Separate charges for diagnostic casts (D0470) are disallowed. Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch or of any repairs, relines, rebases (D5510 through D5761).
D5130, D5140	An immediate denture cannot be used to replace a complete denture. Other restrictions are the same as D5110 & D5120.
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226	Eligible every 7 years and are subject to the same conditions and restrictions listed for D5110 & D5120. Separate charges for diagnostic casts (D0470) are disallowed. The teeth replaced by the appliance must be identified on the claim form.
D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660	Not eligible if the procedure is performed within 6 months of the date of delivery of the appliance. Eligible once per procedure code per 6 months.
D5670, D5671	Eligible only once per 4 years per prosthesis. Not eligible if performed within 4 years of D5213 or D5214. Not eligible for charges for rebase, reline or repairs for 6 months.
D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	Not eligible within 6 months of the date of delivery of the appliance except when an immediate partial/denture is performed. Eligible for any of these procedures only once per 4 years per prosthesis.

ADA Range	Limitations/Exclusions
D5810, D5811	Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim complete denture (D5810 & D5811) in the same arch.
D5820, D5821	Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch.
D5850, D5851	Eligible for two tissue conditioning charges within 6 months of delivery of immediate partial/denture only.
D5863, D5864, D5865, D5866	Charges are subject to the conditions listed for D5110/D5120 and D5213/D5214.
D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6194, D6195	Charges are subject to the same definitions and restrictions listed for D2710 thru D2794 and D6210 thru D6974. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.
D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117	Charges are subject to the same definitions and restrictions listed for D5110 thru D5866. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.
D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6545, D6548, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794	Charges are subject to the same definitions and restrictions listed for D2520 thru D2794. Each unit of a fixed partial denture must be identified on the claim. Not eligible for pontics to replace third molars. All fix prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 7 years of the original placement.
D6930	Not eligible within 12 months of the original cementation. Eligible only once per 12 months per fixed partial denture.
D7210, D7250	Surgical extractions: use when either (1) removal of bone and/or (2) sectioning of tooth, including elevation of mucoperiosteal flap if indicated, is necessary. Surgical extraction charges include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed.

ADA Range	Limitations/Exclusions
D7280, D7283	Eligible once per lifetime. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D7284, D7286	Charges will be disallowed in performed in conjunction with D3410, D3421, D3425, D3426, or D3427.
D7291	Eligible on anterior permanent teeth and bicuspids. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D7310, D7311	Charges are subject to review if performed in conjunction with D7210 thru D7250. Charges not meeting generally accepted standards of care will be disallowed (see D7210 thru D7250).
D7340, D7350	Charges filed in conjunction with implant services will be disallowed.
D7473	Eligible once per arch per lifetime.
D7510	Charges filed in conjunction with definitive treatment will be disallowed.
D7922	Not eligible for more than a combination of two D7922 or D9110 per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.
D7961, D7962	Eligible once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed.

ADA Range	Limitations/Exclusions
D7971	Charges filed in conjunction with definitive restorative treatment will be disallowed.
D9110	Not eligible for more than two palliative (emergency) treatments per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.
D9222, D9223, D9239, D9243	Limited to a total of 30 minutes per date of service.
D9230	Eligible once per date of service.
D9941	Eligible once per 12 months.
D9944, D9945, D9946	Occlusal guards are removable dental appliances designed to minimize the effects of bruxism and other occlusal factors. Eligible once every 5 years. Charges to modify the appliance or for occlusal adjustment are not eligible.
D9973	Eligible on anterior teeth only. Not eligible for retreatment within 3 years of the date of the previous treatment series. Not eligible for home bleaching trays and procedures.
D9974	Eligible on anterior teeth only with history of root canal therapy. Not eligible for retreatment within 3 years of the date of the previous treatment series. Not eligible for home bleaching trays and procedures.
D9995	Eligible one per 12 months.

Orthodontic Benefit Rider

Covered Orthodontic Benefits

Not all plans include benefits for orthodontic treatment. Orthodontic benefits, if included in the dental plan, cover certain orthodontic services and follow certain administration policies as indicated below.

The Standard Plan benefit covers the following orthodontic services:

Limited Orthodontic Treatment	Interceptive Orthodontic Treatment
Comprehensive Orthodontic Treatment	Minor Treatment to Control Harmful Habits

1. The dentist providing orthodontic services must file an initial claim form on behalf of the member and identify when services began, the anticipated length of the treatment period and the total cost of the treatment plan.

2. The Plan will indicate which Plan members qualify for the benefit and/or to what age the member is covered. The Standard Plan benefit covers only dependent children to a certain age, regardless of any treatment that may be in progress. Some Plans also cover adults.

3. The Plan will indicate the payment cycle for which benefits are paid. The Standard Plan benefit payment cycle makes payments of equal installments directly to the dentist on a monthly basis over a period of 24 months. The member must be an active member and be in active treatment during the entire 24 months to receive the full lifetime orthodontic benefit. If the treatment period is less than 24 months, the member's benefit will be paid only over the active treatment period and the full benefit will not be realized. If a non- standard payment cycle is selected, such as over the course of the treatment plan designated with the original claim filing, the terms will be indicated in the Plan. In the event a treatment plan is not defined with the original claim filing, the plan payment cycle will default to 24 months.

4. Active treatment is defined as treatment requiring periodic visits resulting in the movement and retention of teeth.

5. The Plan will indicate the coinsurance percentage that the member is responsible for. The Plan coinsurance may be different based on whether the dentist is a participating network or out of network dentist/orthodontist.

6. The Plan will indicate the amount of the Lifetime Orthodontic Maximum Benefit. A lifetime maximum benefit is the maximum amount paid on behalf of a member during that member's lifetime, regardless of whether a previous employer or carrier paid for the services (subject to availability of claim's information). A member is responsible for the difference between the lifetime maximum and the dentist's fee.

7. Members enrolled after the placement of braces may be eligible to receive benefits for the treatment in progress. The Plan will only consider a benefit based on the remainder of the treatment plan and will require the dentist to submit a claim for the remaining treatment plan. The member's benefit will be paid only over the remaining active treatment period and the full benefit may not be realized.

8. The Orthodontic benefit does not include benefits for lost, stolen, repairs, re-cementation, or replacement retainers. The benefit does not cover the removal of appliances for reasons other than completion of treatment.

9. Orthodontic benefits are paid "monthly" over a period of time and at the designated Plan payment amount in effect at the inception of the member's Orthodontic treatment plan. Adjustments to monthly payments will be made if the Plan Lifetime Annual benefit changes (increases or decreased) during the course of an existing treatment plan. This adjustment will only affect Plans with the Standard Benefit feature. Plans that pay benefits over a treatment plan personal to that member will "lock in" at the inception of a member's treatment plan and will not adjust over the course of the treatment as long as the Plan covers an Orthodontic Benefit. No lump sum payments will be made for any reason.

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1.3432-D.R033023.LR

Paramount Dental Plan

Forest River Out of Network
Group Number 379283275020

Certificate of Coverage

PARAMOUNT DENTAL
Affiliate of ProMedica

Insurance products are marketed by Paramount Dental and underwritten and administered by Health Resources Inc.

This Handbook along with your Summary of Dental Plan Benefits, describes the specific benefits of your Paramount Dental Plan and how to use them.

Visit Paramount Dental Online 24 hours a day/7 days a week at InsuringSmiles.com

Contact Member Services
Paramount Dental
7:00 am – 7:00 pm CST Monday through Friday 800.727.1444
P.O. Box 659, Evansville, IN 47704-0659

DENTAL PLAN HANDBOOK & CERTIFICATE OF INSURANCE

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY

Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary of Dental Plan Benefits conflicts with a statement in this Certificate, the statement in the Summary of Dental Plan Benefits applies to this plan and you should ignore the conflicting statement in this Certificate.

Language Assistance

English	ATTENTION: If you speak English, free language assistance services are available. Call 1-800-727-1444 (TTY: 711).
Español Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-727-1444 (TTY: 711).
繁體中文 Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-727-1444 (TTY 711）。
Tiếng Việt Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-727-1444 (TTY: 711).
Tagalog Tagalog - Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-727-1444 (TTY: 711).
한국어 Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-727-1444 (TTY: 711) 번으로 전화해 주십시오.
العربية Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-727- 1444 (رقم هاتف الصم والبكم: 711)
Հայերեն Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-727-1444 (TTY (հեռատիպ)՝ 711):
Русский Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-727-1444 (телетайп: 711).
日本語 Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-727-1444（TTY: 711）まで、お電話にてご連絡ください。
فارسی Farsi	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-727-1444 (TTY: 711) تماس بگیرید.
ਪੰਜਾਬੀ Panjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-727-1444 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
ខ្មែរ Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-727-1444 (TTY: 711)។
Hmoob Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-727-1444 (TTY: 711).
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-727-1444 (TTY: 711) पर कॉल करें।
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-727-1444 (TTY: 711).
ภาษาไทย Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-727-1444 (TTY: 711).
Deitsch Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-727-1444 (TTY: 711).
ܣܘܪܝܝܐ Syriac	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܬܟܠܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܐܝܬ ܠܘܟܘܢ ܡܬܠܒܬܘܢ ܚܠܝܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘ ܥܠ ܡܢܝܢܐ 1-800-727-1444 (TTY: 711)
Français French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-727-1444 (ATS : 711).
Italiano Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-727-1444 (TTY: 711).

Notice of Nondiscrimination and Accessibility: Discrimination is Against the Law

Paramount complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Paramount does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Paramount provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Paramount Member Services at 1-800-727-1444, for TTY users, 711, 7:00 a.m. to 7:00 p.m. CST, Monday through Friday.

If you believe that Paramount has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. You can file a grievance in person or by phone, mail, fax, or email.

Paramount Dental
1449 Kimber Lane
Ste 103
Evansville, IN 47715

Phone: 1-800-727-1444
TTY: 711
Fax: 812-401-3609
Email: Claims@InsuringSmiles.com

If you need help filing a grievance, Member Services is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW
Room 509F, HHH Building Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Welcome to Your Paramount Dental Plan

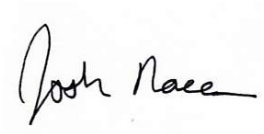
Thank you for enrolling in Paramount Dental! Oral health is a vital part of overall health, and it is our pleasure to be included in your wellness culture. Paramount Dental collaborates with the dental profession to design dental plans that promote oral health care along the most cost effective path. As any dental care professional will attest, the key to avoiding costly dental problems is prevention which starts with you and utilizing the preventive benefits included in your plan. We recommend making your first appointment as soon as possible to ensure you are on the road to great oral health!

You have a wide choice of Network Dentists, both generalists and specialists, nationwide! Network Dentists submit claim forms for services performed for you and payments are paid directly to them. Network Dentists also sign contracts with Paramount Dental to accept certain agreed upon fees, therefore, you and your employer may realize significant savings.

Paramount Dental is also committed to providing the highest quality member services to all Members. Our dedicated team members are available toll-free, Monday through Friday. You may also access information through our website, InsuringSmiles.com. It is your responsibility to be informed about Your Benefits and any associated Limitations and Restrictions, so please read and save this booklet for reference.

Our mission is to offer dental plans that "Improve Your Health and Well-Being". Since 1986, that is exactly what we have delivered to Our Members. We look forward to continuing that promise to our customers.

Sincerely,



Joshua Nace
President - Paramount Dental

This Certificate of Coverage (referred to herein as Certificate) is part of the Master Group Policy that is a legal document (a contract) between Paramount Dental and the Employer. (Referred to herein as We, Us, Our, Paramount Dental, or the Company) and Your Employer Group (referred to herein as Employer) to provide Benefits to Eligible Members (referred to herein as you or your) and is subject to the terms, conditions, Limitations and Exclusions of the Policy. Reasonable effort has been made for this Certificate to represent the intent of the Master Group Policy language between Paramount Dental and Your employer.

Paramount Dental issues this Certificate based on Your Employer Group's Master Group Policy and payment of the required Policy charges. In addition to this Certificate, the Policy includes:

- The Master Group Policy
- Employer Application
- The Summary of Dental Plan Benefits
- Riders
- Amendments

Definitions

Adverse Determination
Any denial, reduction or termination, or a failure to provide or to make payment (in whole or part) of the benefit sought.

Balance Billing
Network Dentists agree to accept the network's contracted fees as payment in full. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as "balance billing" and is not enforceable for Out-Of-Network Dentist as they are under no obligation to limit their fees.

Benefits
The amounts that the Plan pays for Covered Services under a Member's dental Plan. Benefits may be available whether through teledentistry or face-to-face with your Dentist.

Benefit Plan Year
The plan year, unless your employer or organization elects a different period to serve as the Benefit Year.
(See the Summary of Dental Plan Benefits for your Benefit Year.)

Children or Child
Your natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with you during the waiting period for adoption or legal guardianship.

Claim/Claim Form
Standard statement of dental services performed that is submitted by a Dentist or Member to request payment from the Payor. Network dentists always file claim forms on behalf of members and accept payment directly from the Payor. Claim forms are also used to request a pretreatment estimate.

Completion Dates
The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;

- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment / Coinsurance
The Member's share, expressed as a fixed percentage, of the covered dental service.

Coordination of Benefits (COB)
A process that carriers use to determine the order of payment and amount each carrier will pay when a person receives dental services that are covered by more than one benefit plan. COB ensures that no more than 100 percent of the lowest allowable charges for services are paid when a member has coverage under two or more benefits plans (dual coverage) – for example, a child who is covered by both parents' plans.

Covered Services
Dental care services for which a reimbursement is available under a Member's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Custodial Parent
The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the plan year excluding any temporary visitation.

Deductible
The amount a person and/or a family must pay toward Covered Services before Paramount Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Deny/Denied
If a service is denied, the service is not considered a benefit of the patient's coverage and the allowable amount is collectible from the patient.

Dentist
Dental care provider who is skilled in and licensed to practice the prevention, diagnosis, and treatment of diseases, injuries, and malformations of the teeth, jaws, and mouth and who makes and inserts false teeth.

Dependent/Dependent Child
Any Member of a Subscriber's family who meets all the applicable Eligibility requirements, has been enrolled in the plan and for whom the payment required by the employer's group agreement has been received by Paramount Dental.

Dependent Child may include the enrolled employee's biological child, stepchildren, adopted children placed with the enrolled employee whether or not the adoption is final, foster children, children subject to legal court or administrative order to provide health coverage.

Dependent Child also includes any child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. We reserve the right to require proof of incapacity, but not more than annually following the two year period after the child attains limiting age.

Disallow(ed)
If a service is disallowed, the fee is not collectible from the patient by a Network Dentist or the plan.

Effective Date
The date a dental benefits policy begins. Effective date may also be used to describe the date that benefits begin for a Member. The Effective Date is determined in accordance with waiting periods and employment terms enforced by the employer group and applicable State and Federal regulatory entities.

Eligibility
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer.

Eligible Persons –
(Employees + Spouses + Dependents)
An Eligible Member who has met the eligibility requirements set forth by the Enrolled Employee's Employer. Generally, Eligible persons typically include your legal spouses and dependents.

Paramount Dental will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. Dependent children are subject to the employer group's dependent age limitation, which must be no less than age 26.

Dependent child may include the Enrolled Employee's biological children, stepchildren, adopted children, foster children, children subject to legal guardianship, newborn children, or any child for whom the Member is the legal guardian or is required by a court or administrative order to provide health coverage. Coverage for adopted children is effective upon the earlier of: the date of placement or the date of entry of an order granting custody.

Exclusions
Services that are not covered under the Employer Group Dental Insurance Plan.

Explanation of Benefits (EOB)
The statement received after a claim is processed, detailing how Your claim was processed, including

identification of services rendered, fees, application of plan Limitations, calculation of Plan payment, and the amount for which you are responsible.

Fee Charged
The amount that the Dentist bills and is entered on a claim as the charge for a specific service.

Handbook
This document. Paramount Dental will provide Benefits as described in this Handbook. It also serves as your Certificate of Coverage. Any changes in this Handbook will be based on changes to the contract, including the Summary Plan Dental Benefits, between Paramount Dental and your employer or organization.

Lifetime Maximum
The cumulative dollar amount that a plan will pay for dental care incurred by an individual Member for the life of the Member. Lifetime maximums usually apply to specific services such as orthodontic treatment.

Limitations
A list of conditions or circumstances that limit or exclude services from Plan coverage.

Limitations may be related to time or frequency (the number of services permitted during a stated period).

Master Group Policy
The written, legally binding agreement between Paramount Dental and an Employer Group.

Maximum Allowable Amount
The maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meets our definitions of a Covered Service. The maximum allowable/expense is determined by a) the lesser fee of the primary or secondary insurance carrier as it applies to network participation, associated agreed discounts and patient responsibility or b) the fee considered for the global service. For network Dentists, this is the dollar amount that the attending Dentist has agreed to accept as payment in full for the plan and the patient. This amount is shown on the notice that accompanies payment of the claim.

Maximum Allowable Fee
The Maximum Allowable fee amount is the maximum amount of reimbursement the Plan will pay for covered dental services provided by a Dentist to a Member and which meet our definitions of a Covered Service. For Network participating Dentists, the Maximum Allowed Amount will be reimbursed according to a Schedule of Maximum Allowable Charges. Unless specified within the Summary of Dental Plan Benefits of this Policy, the Maximum Allowed Amount for Out-Of-Network Dentists will be reimbursed according to a Table of Allowances as specified in your Summary of Plan Benefits. Paramount Dental's portion of payment for each covered service is the lesser of the Dentist's fee or the maximum allowable fee, minus the co-insurance.

Plan Annual Maximum Benefit
The total maximum dollar amount the Employer Group Paramount Dental Plan will pay toward the cost of dental care incurred by an individual Member in a Plan Year.

Member
A person covered under the Employer Group Paramount Dental Plan. There are two subsets of Members: The Primary Member who is the Employer Group Member under whom the family is enrolled, and the enrolled family members including spouse, domestic partner and eligible children.

Network Dentist
A dentist who contracts with Paramount Dental or leased network carrier and agrees to accept contracted fees as payment in full and abide by certain administrative guidelines.

Network
A panel of Dentists that contractually agree to provide treatment according to administrative guidelines, including limits to the fees accepted as payment in full.

Open Enrollment Period
A period (usually a two-week or one-month period during the year) when qualified individuals (eligible employees) can enroll in or change their choice of coverage in-group benefits plans.

Out of Network Dentist
A dentist who does not contract with Paramount Dental to participate in the network and the associated administrative guidelines including claim submission requirements and maximum allowable fee capitations.

Patient Responsibility
The portion of a Dentist's fee that a Member must pay for dental services, including deductible, coinsurance, any amount over plan maximums, services the plan does not cover and covered services for which the patient is not eligible.

Plan Administrator
The Employer/Sponsor of the Plan or such third party hired by the Employer/Sponsor who performs certain activities for the Plan.

Pre-Authorization
A requirement that recommended treatment must first be approved by the Plan before the treatment is rendered in order for the Plan to pay benefits for those Covered Services.

Premiums

The money billed and paid to Paramount Dental for each month of dental coverage. Payment must be made by an Employer group in order for claims to be paid.

Pre-Treatment Estimate
A non-binding estimate of the benefits available and patient responsibility for a proposed treatment plan after the application of Plan Limitations, restrictions, and exclusions, remaining plan annual maximum and determination of Covered Services.

Qualifying Event
Change in marital status, change in the number of dependents, or change in employment status.

Resin/Composite
Tooth-colored filling material. Although cosmetically superior, it is less durable than other materials.

Submitted/Billed Amount
The amount a Dentist bills to Paramount Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the amount Paramount Dental approves for the treatment.

Subscriber
You, when your employer or organization notifies Paramount Dental that you are eligible to receive Benefits under This Plan.

Summary of Dental Plan Benefits
A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate, and supersedes any contrary provision of this Certificate.

Waiting Period for Plan Eligibility and For Covered Services
Waiting periods are designated by an Employer Group. If an Employer Group establishes a plan-waiting period, it is the stated period of time that a Member must be enrolled in the Plan before being eligible for benefits or for a specific category of benefits. A waiting period limits reimbursement for various services until the insured has been covered for a specific amount of time. Waiting period can apply to specific/individual procedures as well as at the group level.

Eligibility

Paramount Dental is available through employers for their employees. Your Employer selected the Plan and the level of coverage available for You and Your dependents. Coverage provided under the Plan for Employees and their Dependents shall be in accordance with their Eligibility, Effective Date, and Termination provisions of the Plan, including any coverage classifications. For more information, please contact Your Benefits Administrator.

Paramount Dental. Will acknowledge each individual employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight.

Qualified Medical Child Support Order (QMCSO)
Under certain circumstances, You might be required to provide coverage for a child even if You do not have custody, or if the child is not Your dependent. Those circumstances must be established through a Qualified Medical Child Support Order (QMSCO). An Employee who is ordered by a QMSCO to provide dental coverage for a child may enroll himself and such child under the Plan. If Your spouse also has dental insurance, he/she may enroll under your plan but special rules apply (see Coordination of Benefits).

Extended Coverage for a Dependent Child
Paramount Dental will acknowledge each individual Employer's definition for dependent(s) as long as the definition is compliant with the guidelines set forth by the U.S. Department of Health & Human Services, State and other Federal regulatory entities associated with health care regulations and oversight. If You have dependent(s) with a permanent physical disability or mental disability to the extent they cannot support themselves, they may qualify for coverage beyond the applicable age limit for dependent(s). In order to extend coverage, You must provide Us with proof of the child's incapacity and dependency within 120 days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the 2 year period following the child's attainment of the limiting age.

To request special enrollment or obtain more information, contact your Benefits Administrator or Paramount Dental member services.

Enrollment Periods

Initial Enrollment
At the time You enroll, You are given a coverage Effective Date. Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. You must notify Your employer if You have a change of marital status or other Qualifying Event relating to You or Your dependents within thirty (30) days from the time the Qualifying Event occurs. Otherwise, changes may be made only at Open Enrollment or Plan renewal.

Open Enrollment
Open Enrollment is designated by the Employer and is usually the thirty (30) day period immediately preceding the renewal date of Your Employer's policy with Paramount Dental. During this period, You may drop Your coverage or change dependent coverage. Any changes will be effective on the renewal date of Your Paramount Dental Plan.

Special Enrollment
Employees may NOT add, drop or change coverage for themselves and their dependents during the plan year unless a Qualifying Event under HIPAA Special Enrollment, COBRA, or termination of employment occurs. A special enrollment period can occur if an Eligible Employee or Dependent(s) loses coverage under another health plan. A special enrollment period may also begin when Dependent (s) become newly eligible due to marriage, birth, court order, adoption or placement of a child in the home of the Eligible Employee.

The Eligible Employee must request enrollment within 30 days of the Qualifying Event date. During the Special Enrollment Period, the Employee may enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also enroll any newly eligible Dependent(s) of the Employee under the Plan.

Web Services

Paramount Dental offers information and various services on its website. The website is continually revised, improved and enhanced for Your convenience. Members may:

- Find a Network Dentist,
- Verify benefit plan, renewal dates, dependent coverage, Claim status,
- Print Member Cards,
- Review benefit history,
- Download brochures and Certificates, and
- Acquire oral health and wellness tips.

Online materials serve as the primary source of information for groups, Members, dentists and advisers. Any printed documents that you may have is based on information at a certain point in time and may not be inclusive of all benefits, restrictions and limitations. All documents may also be requested by contacting our Customer Service Center at: 1-800-727-1444.

Member ID Card

A Paramount Dental Member ID Card will be issued to you upon enrollment.

Selecting a Dentist – Receiving Dental Care

Dentistry is a highly personal service. You may have any dental treatment performed as decided by You and Your dentist. Your Dental Plan does not dictate what treatment You receive. Only You and Your dentist can determine that. However, Your Plan does determine what services are covered and by what type of dentist (In-Network vs. Out-of-Network). The coverage selected by Your Employer pays for only those Covered Services under Your Paramount Dental Plan listed in this certificate and Summary of Dental Benefits within the Limitations and restrictions presented. You must personally pay for any service which is not covered or for any service that is covered but is subject to Limitations and restrictions. Your Claim will only be processed after completion of the dental service. If You are not sure whether a particular dental treatment is covered or how much You will be required to pay, You may request a Pre-Treatment Estimate from Your dentist. It is a free service offered by Paramount Dental and highly encouraged so you are never surprised about your dental coverage.

Some services are limited by the age of the patient, by how often the service may be performed, or by specific teeth. All time intervals (frequency limitations) required by coverage are independent of calendar year or plan year. Frequency limitations regarding how often services may be performed are continuous. Change of dental plan coverage, termination and reinstatement of coverage does not eliminate the frequency limitations.

Paramount Dental also offers a large, nationwide, network of credentialed dentists to accommodate oral health needs of You and Your family. Simply visit the Find a Dentist link on InsuringSmiles.com, to view a complete listing of general and specialty Network Dentists in Your geographical area. The Network listing generated from the website includes access to all Paramount Dental and leased Networks included in your Plan offered by your Employer that is outlined your Summary of Dental Benefits. Network Dentists provide the same excellent service at a contracted fee, resulting in savings for You and Your family.

You should always verify the plan and your Summary of Dental Plan Benefits selected by Your Employer prior to Your dental visit as it makes a difference in Your coinsurance and savings. Network Dentists are independent contractors and are not Paramount Dental employees.

Benefit Categories – What is Covered by My Plan?

Important - It is very important to understand that your employer will select which plan services are included in your plan. Please review both this Certificate and the Summary of

Dental Plan Benefits carefully. **ONLY the dental services listed in your Summary of Dental Plan Benefits will be covered by your plan.** The Summary of Dental Plan Benefits is part of this Certificate and supersedes any provision of this Certificate. Covered services are also subject to exclusions and limitations and are included in a later section of this certificate.

The various dental services provided by a dentist are classified into the following categories:

1. Diagnostic and Preventative
2. Restorative
3. Endodontic
4. Periodontics
5. Prosthodontics (removable and fixed)
6. Oral Surgery
7. Orthodontics
8. Adjunctive

Diagnostic and Preventive Services

These services are important to your overall oral health and the detection and prevention of dental disease. They include examinations and evaluations (routine and problem focused), prophylaxes (routine teeth cleanings), radiographs (x-rays), fluoride treatments, and sealants and space maintainers (for children).

Restorative Services

- Minor Restorative Services – these procedures rebuild and repair your teeth damaged by disease, decay, fracture or injury. Both amalgam (silver) and composite (white tooth colored) fillings on baby and adult teeth and anterior and posterior teeth are considered in this category.
- Major Restorative Services – these services include crowns and crown related services. Crowns may be covering a natural tooth or an implant.

Endodontic Services

These procedures treat teeth with diseased or damaged nerves. Root canals are included in this category.

Periodontic Services

- **Non-surgical Periodontics Services** – these procedures involve the treatment of diseases of the gums and supporting structures of the teeth. Nonsurgical procedures include periodontal scaling and root planning, full mouth debridement and periodontal maintenance following a periodontal therapy (periodontal cleanings).
- Surgical Periodontal Services – procedures that related to surgery of your gums which can include osseous surgery and gingivectomy.

Prosthodontic Services (fixed and removable)

- Bridges, partial and complete dentures are in this category.
- Relines and Repairs – these procedures reline and repair existing dentures (partial and complete) and repair existing bridges.
- Implant Services – the placement of an endosteal implant and the associated abutment.

Oral Surgery

- Simple Extractions – this procedure is an extraction of a tooth that is erupted or exposed root.
- Surgical extractions of tooth/teeth are included in this category and include the removal of impacted teeth and other extractions including removal of bone. An incisional biopsy of oral tissue for the detection of cancer or other suspected disease is also included in oral surgery services.

Adjunctive/Other Services

Your Summary of Dental Plan Benefits will list any other benefits that may have been selected.

Orthodontic Services

A “Rider” to your Plan must be selected and included in your Summary of Dental Plan Benefits to have Orthodontic Services covered. Orthodontic covers traditional braces, clear orthodontic treatment (Invisalign) and removable appliances. Retainers are considered part of the orthodontic treatment.

How Payment is Made for These Benefits Categories

When filing claims, your dental office will use the appropriate dental code(s) found in the American Dental Association’s current CDT Code Book. The codes are too numerous to list, however the staff at your dental office is well versed in using these codes and the staff can explain them more thoroughly at your request.

It is best, though not necessary, to have your dentist file a pretreatment estimate for services totaling over $300 to fully identify what benefits are available to you. This will avoid any confusion as to the balance you may owe your dentist. Not all plans cover the same procedures, and if there is any doubt to the coverage of your plan a representative of Paramount Dental would be glad to go over it with you. Your dentist also has access to your specific coverage and can review it with you.

Coinsurance

Covered Services and the percentage of covered expense provided by the Plan and limitations to covered services are indicated on Summary of Dental Plan Benefits. The percentage of plan payment (coinsurance) is valid only for services obtained from participating network Dentists contracted with Paramount Dental or a leased network. A participating network Dentist has agreed to not bill the patient for the difference between his fee charged and the contracted maximum allowable fee. This is referred to as

"balance billing" and is not enforceable for Out-of-network Dentists as they are under no obligation to limit their fees.

Plan Features

This list of plan features describes the features that are available through Paramount Dental but may not be included in the coverage that you or your employer has selected. To see a list of plan features that are specific to your benefit coverage, please refer directly to Summary of Dental Plan Benefits. If a plan feature is not listed on your Summary of Dental Plan Benefits then it is not a part of your Dental Benefit Plan.

Plan Annual Maximum Benefits/Plan Year

Benefits payable under the Plan, regardless of whether coverage is continuous or not, shall be subject to the Plan Annual Maximum for each plan year. Payments under your Certificate for ALL Covered Services apply to the Plan Annual Maximum benefit excluding orthodontic services. Change of the dental plan coverage, termination, and reinstatement of coverage does not eliminate frequency limitations or Plan Annual Maximum benefit used.

Annual maximum benefits are based on a policy/benefit year unless otherwise noted on the Summary of Dental Plan Benefits beginning with the Plan's effective date of coverage,

After the Plan Annual Maximum Benefit is exhausted, you are responsible for all subsequent charges to your dentist.

Lifetime Maximum Benefit – Orthodontics

If your plan includes orthodontics coverage, your Summary of Dental Benefits will list a lifetime maximum of orthodontic benefits per member. This is the cumulative dollar amount that will be paid for orthodontic dental care for the life of the Member.

Deductible

The Plan Year Deductible (if any) is applicable to Covered Services incurred in each Plan Year. Your policy will determine the Deductible application method chosen by Your employer. The available methods include:

Out of Pocket Deductible-

An out of pocket deductible is the specified & consistent amount reduced from the plan's covered expense which must be paid in full by the Member each plan year. It is applied chronologically according to the dates in which the Covered Services were completed and increases the patient responsibility by the specified amount until the earlier of two events 1) individual deductible is met, or 2) family deductible is satisfied.

Ex: (Fee Allowed X Co-Insurance) – Deductible = Plan Payment

Patient A receives major services covered at 50% under the plan. This patient is responsible for a $50 individual deductible.

Benefit Deductible

A benefit deductible is the amount a Member must pay toward Covered Services before the carrier will reimburse for those Covered Services. This amount may vary based upon the co-insurance of the Covered Service.

Ex: (Fee Allowed – Deductible) X Co-Insurance = Plan Payment
Patient B receives major services covered at 50% under the plan. This patient is responsible for a $25 individual deductible.

Waiting Period

The Waiting Period is the period of time beginning on the Member's Effective Date before benefits for certain Covered Service become eligible for reimbursement. Unless otherwise specified, the most recent effective date is utilized in the application of the Waiting Period, this includes a change to Your dental plan coverage such as termination and reinstatement of coverage.

Alternate Benefits

There is often more than one service that can be used to appropriately treat a dental problem or disease. In determining the benefits payable on a claim, different materials and methods of treatment will be considered. If applicable, the amount payable will be limited to the Covered Expense for the least costly Service, which meets broadly accepted standards of dental care as determined by Us. A Member and his Dentist may decide on a more costly service or material than We have determined to be satisfactory for the treatment of the condition. In this case, the Plan will be a benefit toward the cost of the more expensive service or material, but the payment will be limited to the benefits payable for Covered Expenses for the least costly Covered Service.

Unbundling

When charges for less complicated Services performed in conjunction with the more comprehensive/extensive definitive treatment are separated, these less complicated components may be considered as parts of the primary Service. If the Dentist bills separately for the primary Service and each of its component parts, the total benefit payable for all related charges will be limited to the benefits payable for Covered Expenses for the primary Service.

Service Exclusions

Paramount Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Benefits. All charges for the same will be your responsibility (though your payment obligation may be

satisfied by insurance or some other arrangement for which you are eligible):

General Exclusions
All Master Group Policies and Certificates issued or administered by Paramount Dental are subject to the following General Exclusions.

This plan will not pay for:

1. Dental services that are not listed in the Plan Covered Services and Plan General Exclusions, Limitations and Restrictions attached to this Certificate.
2. Claims for dental services rendered before the Effective Date or after coverage is terminated.
3. Claims for dental services covered under non-dental insurance.
4. Claims for services performed primarily to rebuild occlusion or for full mouth reconstruction.
5. Claims for Enrollees until Paramount Dental receives the appropriate contracted payment(s) for Premiums.
6. Claims for services which are not completed.
7. For duplicates, lost, or stolen prostheses, appliances, and/or radiographic images.
8. A Claim must be received within one year from the date of service.
9. Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous (baby) teeth.
10. Orthodontic treatment, unless otherwise specified in your Summary of Dental Plan Benefits.
11. Treatment of temporomandibular joint or jaw joint disorder (TMJ).
12. Dental services provided by a non-network participating dentist to the extent that the charges exceed the amount payable for services under the nonparticipating dentist fee schedule.
13. Pediatric dental Essential Health Benefits (EHB) as mandated by the Affordable Care Act (ACA).
14. Dental services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.
15. Dental services or charges separately billed by hospitals, laboratories, pharmacies or other institutions other than a dentist practice.
16. Experimental or investigational dental treatment.
17. Dental services as a result of your participation in a misdemeanor, felony, riot or insurrection.
18. Dental services charged and filed on a claim under an unspecified CDT service code X999.
19. Submitted claims for which Paramount Dental has not received the dentist documentation (federal W9 form, documentation requirements – radiographs, primary explanation of benefits, etc., or unable to process due to incorrect filing information) required to determine and finalize the claim benefit.

Service Limitations

The benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Paramount Dental plan or, at the request of your group, any dental plan:

Diagnostic Evaluations and Treatments
Evaluations (examinations), including any and all procedure codes, are payable as stated in your Summary of Benefits. These include all examinations and evaluations performed by any general dentist or specialist.

A comprehensive oral evaluation or a comprehensive periodontal evaluation for a new or established patient is payable according to the time period specified in your Summary of Benefits. A comprehensive periodontal evaluation will only be payable for members that are age 14 and above.

Diagnostic Imaging, Tests, and Examinations
The maximum amount considered for all radiographic images (also referred to as X-rays) taken on one day will be equivalent to an allowance of a full mouth X-ray. The difference may not be billed to the Enrollee.

Panoramic (including image capture only) or full mouth X-rays are payable according to your Summary of Benefits. If a full mouth X-ray is performed within 12 months of any bitewing image(s), the allowable amount for the full mouth X-ray will be reduced by the charges for bitewing(s). Panoramic or full mouth X-rays will not be payable if performed within 12 months of a set of vertical bitewings images.

Periapical images (including image capture only) are payable up to a maximum of 3 during a 12-month period.

Occlusal images (including image capture only) are payable only once per arch per 12 months.

Vertical bitewings (including image capture only) are payable once per 12 months unless a complete series of images or four bitewings were paid in that same 12 months.

Bitewing radiographic images (including image capture only) are limited to the amount specified in your Summary of Benefits. Bitewings will not be payable if performed within 12 months of a complete series of images or a set of vertical bitewings images.

2D cephalometric images or 2D oral/facial photographic images (including image capture only) will be payable only if performed in conjunction with a Plan that covers orthodontic services and treatment. Cephalometric images are payable

every 2 years unless image captures only were paid during the same 2 years. 2D oral/facial images are payable every 5 years unless image captures only were paid during the same 5 years.

Pulp vitality tests are payable for one charge per date of service.

Diagnostic casts are payable once per 5 years and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Preventive Services:
Prophylaxis: A teeth cleaning (includes prophylaxis, periodontal scalings and root planning, periodontal full mouth debridement and periodontal maintenance) is payable according to the limitations listed in your Summary of Benefits., regardless of the dentist's specialty. A teeth cleaning for children under the age of 14 will be payable when filed as a child's cleaning.

Fluoride: A preventive fluoride treatment is payable as listed in your Summary of Benefits.

Sealants: Will be payable on permanent molar teeth (per tooth) as listed in your Summary of Benefits. A replacement for a sealant will not be payable for a period of 5 years. If a sealant was applied to a tooth, a restoration on the same tooth will not be payable for a period of 3 years.

Space Maintenance: Space maintainers are payable once every 3 years for children under 13 years of age The re-cementation or re-bonding of a space maintainer is payable only after 12 months after the initial placement and only once per 12 months.

Restorative Services:
A restoration/filling (amalgam or resin-based composite) is payable as listed in your Summary of Benefits. An additional restoration on the same tooth surface will not be payable for a 2-year period. A restoration will not be payable within 2 years of placing a crown on the same tooth or a sealant on the same surface within 2 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered for payment.

Crowns, or Inlays/Onlays (in any combination including implant supported) are payable as listed in your Summary of Benefits. A charge for a crown or an inlay/onlay on a tooth following the placement of an amalgam or resin-based composite restoration on the same tooth is not eligible for payment for a period of 2- years. Crowns, other than prefabricated steel crowns, are not payable for primary teeth. Composite/resin inlays must be laboratory processed.

A resin-based composite (indirect) crown is payable on anterior teeth only.

Individual crowns over implants are payable as listed in your Summary of Benefits.

Not all crowns or inlay/onlays procedure codes are considered covered if a corresponding procedure code using new and advanced materials is determined to be available.

Crowns, inlays/onlays may be subject to review for extensive loss of tooth structure due to caries (decay) or fracture to determine coverage. A pre-treatment estimate is recommended to determine coverage.

A recementation of an inlay, onlay, or crown is payable only once per 12 months and will not be considered for payment if within 12 months of the original cementation.

A protective restoration is payable once every 2 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for a subsequent definitive treatment are subject to an adjustment if performed within 12 months of a protective restoration.

A core buildup will not be payable if performed as specified in your Summary of Benefits. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed. A pre-treatment estimate is recommended to determine coverage.

A pin retention is payable per tooth and limited to posterior teeth only. Additional pins will be disallowed.

A post and core in addition to a crown is payable once per 5 years per tooth. A payment is not eligible if performed within 5 years of a core buildup or another post and core. Procedure is not payable without history of root canal therapy.

Endodontics:
A therapeutic pulpotomy is payable for primary teeth only and only once per tooth per lifetime. Charges are exclusive of the final restoration charge.

All pulpal and endodontic therapy and apexification/recalcification should be coded by the tooth receiving treatment, not the number of canals per tooth. A single periapical will be considered for payment with an endodontic therapy or an apexification/recalcification only (not pulpal). Separate fees for other radiographs and images are considered part of the treatment plan and will be

disallowed. Charges are exclusive of the final restoration charge. Charges for “elective” root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.

Pulpal therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Endodontic therapy is not eligible for payment for retreatment within 4 years of the date of the original treatment.

Apexification/recalcification is limited to children under 16 years of age and once per lifetime. Not eligible for payment for retreatment within 4 years of the date of the original treatment.

An apicoectomy is payable only once per lifetime.

A canal preparation and fitting of preformed dowel or post is payable once per 7 years. Charges will be disallowed if submitted in conjunction with a post and core, fabricated post, or prefabricated post/core.

Non-Surgical and Other Periodontal Services:
Periodontal maintenance is payable as listed in your Summary of Benefits. This procedure will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a scaling in the presence of gingival inflammation, or a full mouth debridement.

A scaling and root planing (4 or more active periodontal diseased and qualified teeth) is payable as listed in your Summary of Benefits. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling in the presence of gingival inflammation, a full mouth debridement or periodontal maintenance. The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Not payable on deciduous teeth. This procedure requires the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. Charges not meeting established criteria will be disallowed. A pretreatment estimate is recommended to determine coverage. Dental Review Team maintains discretionary authority regarding review requirements.

A scaling in presence of generalized moderate or severe gingival inflammation – full mouth is payable once every 5 years and only for enrollees over 15 years of age. Will not be payable if performed within 6 months of or same date of service as a prophylaxis, a scaling and root planning, a full mouth debridement or periodontal maintenance.

A full mouth debridement is payable only for enrollees over 15 years of age. Procedure is payable once every 3 years and 3 years must lapse between any associated periodontal scalings (scaling and root planning and scaling in the presence of gingival inflammation) were performed. Will not be payable if performed within 6 months of or the same date of service as a prophylaxis, a scaling and root planning or a scaling in the presence of gingival inflammation, or periodontal maintenance.

Periodontic Surgical
The following services are payable only once per area treated within a 5-year period:

- Gingivectomy or gingivoplasty (four or more teeth/tooth per quadrant only)
- Clinical crown lengthening (per tooth)
- Osseous surgery
- Guided tissue regeneration (includes barrier and its removal, as necessary)

Two tissue grafts (of any type, including pedicle soft, autogenous connective, non-autogenous connective, and free soft) are payable once per area treated/quadrant every 5 years. Teeth #24-25 are considered one site.

Prosthodontics:
One upper and one lower denture (including complete, immediate, partial, immediate partial, overdenture and interim) are payable as listed in your Summary of Benefits. Charges for a conventional, removable partial dentures or a complete denture are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch or of any repairs, relines, rebases. Separate charges for diagnostic casts will be disallowed. An immediate denture will not be payable if used to replace a complete denture.

A repair to a complete or partial denture is payable once per 6 months only after 6 months has elapsed since the initial date of delivery of the appliance. A repair to a partial denture that replaces all teeth and acrylic on framework is payable once per 4 years only after 4 years has elapsed since the initial delivery of the appliance

A rebase or reline to a complete or partial denture is payable once per 4 years only after 6 months has elapsed since the initial date of deliver of the appliance.

Two tissue conditioning charges will be payable only within 6 months of delivery of immediate partial/denture only.

Fixed partial dentures, including partial denture pontics (non-resin), partial denture retainers (cast metal and porcelain/ceramic retainers only), and partial denture retainers-crowns (non-resin) are payable as listed in your Summary of Benefits. Charges are subject to the same definitions and restrictions as single restoration crowns. Each unit of a fixed partial denture must be

identified on the claim. Not eligible for pontics to replace third molars. All fixed prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 5 years of the original placement.

A re-cement or re-bond of a fixed partial denture is payable only once per 12 months per fixed partial denture and only after 12 months of the original cementation.

Oral Surgery:
Surgical extraction of an erupted tooth requiring removal on bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated, and the removal of residual tooth roots procedures include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed.

An exposure of an unerupted tooth or the placement of a device to facilitate the eruption of an impacted tooth will be payable only once per lifetime if the procedure is performed in conjunction with a Plan orthodontic covered services and treatment.

An incisional biopsy of soft oral tissue will be disallowed if performed in conjunction with an apicoectomy.

A transseptal fiberotomy/supra crestal fiberotomy is payable only on anterior permanent teeth and bicuspids and only if the procedure is performed in conjunction with the Plan orthodontic covered services and treatment.

Alveoplasty in conjunction with routine extractions are subject to review. Charges not meeting generally accepted standards of care will be disallowed.

Vestibuloplasty, ridge extension, procedures charges in conjunction with implant services will be disallowed.

Removal of torus mandibularis is payable only once per arch per lifetime.

Incision and drainage of abscess filed in conjunction with definitive treatment will be disallowed.

A frenectomy is payable once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed.

Excision of pericoronal gingiva filed in conjunction with definitive restorative treatment will be disallowed.

Implant Services
A surgical placement of an implant body (endosteal) or a mini implant is payable as listed in your Summary of Benefits. Allowance includes the treatment plan, local anesthetic and post-surgical care. Coverage is limited to enrollees over 15 years of age.

A prefabricated abutment or a custom fabricated abutment is payable once per 5 years per tooth site. Coverage is limited to enrollees over 15 years of age.

Single crowns and fixed partial denture retainers (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported single crowns and fixed partial dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Removable dentures and fixed dentures (abutment or implant supported) will be payable once every 5 years and subject to the same limitations as non-implant supported removable dentures and fixed dentures. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.

Adjunctive/Other Services Limitations
Palliative (emergency) treatments will be payable 2 per 12-month period. Charges filed in conjunction with definitive treatment will be disallowed.

Deep sedation/general anesthesia and intravenous moderate (conscious) sedation/analgesia will be payable up to a total of 30 minutes per date of service.

Inhalation of nitrous oxide/analgesia will be payable once per date of service.

An athletic mouth guard is payable once per 12 months.

Occlusal guards are payable once every 5 years. Charges to modify the appliance or for occlusal adjustment are not payable.

Teledentistry benefits are payable as specified in your Summary of Benefits.

Disallowed Services

Participating Dentists may not charge eligible persons for disallowed services or supplies. All charges fromnon-participating dentists for the disallowed services areyour responsibility.

How Payment Is Made

In-Network Dentists
In-Network Dentists are responsible for submitting claims to Paramount Dental on Your behalf for rendered services. Paramount Dental will reimburse the In-Network Dentist directly for Covered Services.

A Member is responsible for the Deductible and any out-of-pocket expenses required by the Plan including the co-insurance and the cost of services that are not covered by the Plan. It is possible that Your dentist's charges for one or more of the services may be higher than the maximum allowable under Your Paramount Dental. If so, an In-Network Dentist must reduce the charged amounts. If a Member is billed by an In-Network Dentist for a Covered Service (other than the Deductible, co- insurance, or amount above the maximum allowable fee), the Member should contact either the In-Network Dentist or Paramount Dental.

Out-Of-Network Dentists
If You visit an Out-Of-Network Dentist, you may be personally responsible for submitting claims directly to Paramount Dental. Some Out-Of-Network Dentist will file the claim as a courtesy to their patients, but they are under no obligation to do so. A Member must provide all of the information the Plan needs to process such claims, including an ADA approved claim form, an invoice of the charges and proof of payment. If a Member does not provide this information, a Member may not be paid or the payment will be distributed to the Out-Of-Network Dentist.

A Member is responsible for the Deductible, any out-of-pocket expenses required by the Plan including the coinsurance and the cost of services that are not covered by the Plan, and any charges above the maximum allowable for the service.

Your out-of-pocket expenses will most likely be higher by seeing an out-of-network dentist because your dentist can Balance Bill the amount that is not covered by Paramount Dental to you and you are responsible for all charges not covered by your Dental Plan.

Filing a Claim
Network Dentists are responsible for submitting claims to Paramount Dental on your behalf. Out-Of-Network Dentist may file the claim as a courtesy to their patients, but are under no obligation to do so. All claims should be submitted to the Paramount Dental address provided in a separate section of this document. The following information should be included on a standard ADA claim form:

1. Covered Employee's name, address, and identification number (SSN)
2. Patient's name, date of birth, and identification number (SSN)
3. Itemized bill including the ADA code, description of each charge, and date of service
4. Name and address of the Rendering Dentist
5. Rendering Dentist's Tax ID Number (W-9 Form)

Note: To be considered for payment, a claim must be submitted within 1 year from the date of service. Some services may require additional information, such as a radiograph image or a periodontal chart before being processed. Benefit payment can only be determined at the time that that claim is submitted with all required documentation. Reference the Plan General Exclusions, Limitations, and Restrictions, including provider supporting documentation provision for more information.

Notice of Claim

We must receive written notice within sixty (60) days after a Claim starts or as soon as reasonably possible. Failure to give notice within that time will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give notice at that time, but such notice was given as soon as was reasonably possible. The notice shall be sent to Paramount Dental or given to Our agent. Notice given by or on behalf of the Member or the Member's beneficiary to Us or to any of our authorized agents with information sufficient to identify the Member is considered notice to Us. If You visit an Out-of-Network Dentist, You may personally be responsible for submitting Claims directly to Paramount Dental.

Claim Forms

Your dentist will file Your claim or provide You with the forms necessary to file the claim. If Your dentist does not provide these forms within fifteen (15) days, You may send Us a written statement to satisfy this requirement. This statement should include enough information to identify You as well as the nature and extent of the Claim. It should be sent to Us within the time stated in the Proof of Loss provision.

Once Paramount Dental processes Your dental Claim, You will receive an Explanation of Benefits explaining payment amounts. It is possible that Your dentist's charges for one or more of the procedures may be higher than the maximum allowed under Your Paramount Dental. If so, a contracted Network Dentist must reduce the charged amounts. An Out-of-Network Dentist may charge You for the difference since they are not contractually liable to accept Your plan's fee schedule.

Proof of Loss

We must receive written proof of loss within ninety (90) days of a Claim. If it is not possible for proof to be provided within

the ninety (90) days, We will not deny a Claim for this reason if We receive the proof as soon as possible. In any event, We must receive proof no later than one year from the time specified, unless You are legally incapacitated.

Time of Payment of Claims

Benefits for loss covered by the Policy will be paid when Paramount Dental receives all information necessary, including premium payment, to correctly adjudicate the claim, but not more than thirty (30) days after receipt of all necessary information. Upon the Member's death, any payments outstanding will be paid, at our option, to the Member's beneficiary or to the Member's estate.

If We fail to pay or deny a clean claim in the time required, and We subsequently pay the claim, We will pay the provider that submitted the claim interest on the allowable amount of the claim.

Legal Actions

A legal action may not be brought against Us before sixty (60) days, or after three (3) years, from the date written proof of loss is required to be given.

Coordination of Benefits

Coordination of Benefits ("COB") applies to this plan when an eligible person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether this plan's benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Terms:

1. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    a. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

    b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, which is associated with a Covered Service for which reimbursement is available or for which reimbursement would be available but for the application of contractual limitations. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

4. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the plan year excluding any temporary visitation.

5. Benefit reserve is the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

Order of Benefit Determination Rules:

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
3. Each Plan determines its order of benefits using the first of the following rules that apply:

a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the [calendar] year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(2) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

(3) For a Dependent Child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

f. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan:
When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right To Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Paramount Dental may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Paramount Dental need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Paramount Dental any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan or plans, Paramount Dental will have the right, exercisable alone and at its discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision. The amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments; Paramount Dental will be fully discharged from liability under the Plan. The benefits that are payable in accordance with this provision will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this provision.

Right of Recovery
Whenever payments have been made in excess of the amount due under the Plan, the Paramount Dental shall have the right, exercisable alone and in its sole discretion, to recover such excess payments from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

Termination of Coverage

Your dental coverage may be automatically terminated:
When Your employer advises Paramount Dental to terminate Your coverage;

When Your employer fails to pay timely Premium payments or fees to Paramount Dental; or

For any other reason stated in the Policy.

A person whose Eligibility is terminated may not continue coverage under their Employer's contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) or comparable, nonpreempted state law.

Continuation of Coverage

Continuation Coverage Rights Under The Consolidated Omnibus Budget Reconciliation Act Of 1985 (COBRA)

Introduction
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to an Enrolled Employee who would otherwise lose coverage under the Plan. It can also become available to Enrolled Dependents covered under the Plan when they would lose their coverage under the Plan. For additional information about your rights and obligations under the Plan and under federal law, you should review the COBRA Procedures or contact the Plan Administrator. In the event that an individual receives a COBRA election form with incorrect plan information, the Plan will notify the individual of the accurate Plan terms. The election will be in accordance with the accurate Plan benefit, terms, and coverage.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage will be offered to

each person who is a "Qualified Beneficiary." The Enrolled Employee and each Enrolled Dependent could become Qualified Beneficiaries if coverage under the Certificate is lost because of the Qualifying Event. Under the Master Group Policy, Qualified Beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

An Enrolled Employee will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of either the following:

- Hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct by the Enrolled Employee.

An Enrolled Spouse will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of the following:

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

An Enrolled Child will become a Qualified Beneficiary if coverage under the Master Group Policy ends as a result of any of the following:

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

When is COBRA Coverage Available?

The Master Group Policy will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

Enrolled Employee or Dependent must notify the Plan Administrator within 60 days after the Qualifying Event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children who are Qualified Beneficiaries.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Enrolled Employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the divorce or legal separation of the Enrolled Employee, or an Enrolled Dependent losing eligibility for coverage under the Certificate as a Dependent Child, COBRA continuation coverage lasts up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Enrolled Employee's hours of employment, and the Enrolled Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage. If an Enrolled Person covered under Your Certificate is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, each Enrolled Person may be entitled to receive up to an additional 11 months of COBRA continuation coverage (while the disability continues), for a total maximum of 29 months.

Second Qualifying Event extension of 18-month period of continuation coverage
If an Enrolled Person experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the Enrolled Spouse and Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator.

Questions concerning Your Certificate, the Master Group Policy or Your COBRA continuation coverage rights should be addressed to Your Plan Administrator or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area (EBSA Regional Office: Cincinnati Regional Office, 1885 Dixie Highway, Ste 210, Ft. Wright, KY 41011-2664, Tel 859.578.4680/Fax 859.578.4688) or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Change In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members.

Questions and Assistance

Questions regarding your policy or coverage should be directed to:
Claims Department Paramount Dental.
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

General Conditions and Additional Information

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan. No failure to enforce any provision of the Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

Entire Contract & Changes

The Policy, including the endorsements, Certificates, Summary of Dental Plan Benefits, riders, application and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy will be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. We will consider any statement made by You or the Employer, in the absence of fraud, as a representation and not a warranty.

We may amend coverage, limitations to the Covered Services, General Exclusions, Annual Maximum, benefit payments or any other terms of this Certificate or the Master Group Policy upon thirty (30) days written notice to You and Your employer. This Certificate will pay for any Covered Services rendered prior to the Effective Date of the change. If there are any discrepancies as to coverage, limitations to Covered Services, General Exclusions, Annual Maximum or other provisions stated herein and as stated in the Master Group Policy, the provisions of the Master Group Policy will supersede those set forth herein.

Claims Appeal Procedure

Informal Claims Appeal Procedure
Your Paramount Dental plan has been carefully designed to provide You with the maximum amount of covered benefits for Your level of payment/Premium. Since Paramount Dental is always looking for ways to make Our Master Group Policies and Certificates even better, Your suggestions are encouraged. Occasionally, even after You have reviewed the applicable sections of this Certificate pertaining to Your issue at hand, You may have a question. Your questions may involve dentists, Covered Services, the agents who sold and serviced Your Paramount Dental plan, policies, or procedures.

Paramount Dental always notifies You or Your authorized representative of a benefit determination after Your Claim is filed. This notice is made via an Explanation of Benefits (EOB). An adverse benefit determination is any denial, reduction or termination of the benefit for which You filed a Claim, or a failure to provide or to make payment (in whole or in part) of the benefit You sought. This includes a determination based on Eligibility, the administration of Covered Services, Limitations or restrictions, and payment amounts. If You receive notice of an adverse benefit determination, and if You think that Paramount Dental incorrectly denied all or part of Your Claim, You may take the following steps:

First, You or Your dentist should contact Paramount Dental's Member Services team and ask them to check the Claim to make sure it was correctly processed. If You contact Us in writing, please enclose a copy of Your Explanation of Benefits and describe the problem. Paramount Dental provides this opportunity for You to describe problems and submit information that might indicate that Your Claim was improperly denied and allow Paramount Dental to correct this error quickly.

Formal Claims Appeal Procedure
Whether or not You have contacted Paramount Dental informally, as described above, to recheck the initial determination of Your Claim, You or Your authorized representative may submit Your Claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of Your Claim, You must send Your request in writing to the Dental Claims Review Team at Paramount Dental.

You must include Your name and address, the Member's ID number, the reason You believe Your Claim was wrongly denied, and any other information You believe supports Your Claim, including sections of Certificate that support Your appeal. If You would like a record of Your request and proof that is was received by Paramount Dental, You should mail it certified mail, return receipt requested. You or Your authorized representative should seek a review as soon as possible after You receive Your EOB; however, You must file Your appeal within ninety (90) days of the date of which You receive Your notice of the adverse benefit determination You are asking Paramount Dental to review.

The Dental Claims Review Team will make their decision and notify You in writing within 30 days of receiving Your request. Their notice of any adverse determination will: (a) inform You of the specific reasons for the denial; (b) list the pertinent Master Group Policy/Certificate provision on which the denial is based; (c) contain a statement that You are entitled to receive upon request and at no cost, reasonable access to and copies of the documents, records and other information relevant to the decision to deny Your Claim; and (d) contain a statement that You may seek to have Your Claim re-evaluated by the appropriate Department of Insurance in Your state of domicile. You may also have the right to seek to have Your Claim paid by filing a civil action in court.

Notice of Privacy Practices

In compliance with certain applicable laws, the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Paramount Dental has adopted these policies. Paramount Dental acknowledges participants' privacy rights as specified in these laws, and has adopted policies and procedures to ensure Your privacy rights are protected.

This Notice describes how nonpublic personal financial information (NPFI) and protected health information (PHI) about You may be used and disclosed and how You can access this information. In this Notice, We explain how We protect the privacy of Your NPFI and PHI, and how We will allow it to be used and given out (disclosed). We are required to provide You with a copy of this Notice of privacy practices upon request. We must follow the privacy practices described in this Notice while it is in effect.

Our Commitment Regarding Your Confidential Information:
We understand the importance of Your NPFI and PHI (hereafter known as Confidential Information), and follow strict policies (in accordance with state and federal privacy laws) to keep Your information private.

Our Privacy Principles:

- We do not sell customer Confidential Information.
- We do not provide customer Confidential Information to persons or organizations outside Paramount Dental and Our business associates for marketing purposes.
- We contractually require any person or organization providing products or services on Our behalf to protect the confidentiality of information We obtain from You.

We afford prospective and former customers the same protections as existing customers with the respect to the use of Confidential Information. Your privacy is a high priority for Us and it is treated with the highest degree of respect. We collect and use Confidential Information We believe is necessary to administer Our business and to provide You with customer service. We use Confidential Information to underwrite Your policies, process Your Claims, ensure proper billing, and service Your accounts. We share Confidential Information as necessary to handle Your Claims and to protect You against fraud and unauthorized transactions. However, We want to emphasize that We are committed to maintaining the privacy of this information in accordance with law. All individuals with access to Confidential Information about Our customers are required to follow this policy.

Confidential Information Collected:

- Confidential Information includes demographic data that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health, the provision of health care to You, or the payment for that care.
- Confidential Information includes Your name, address, date of birth, marital status, sex, social security number, dental information, and Enrollee information, including information about Your transactions with Us, such as Claim history and Premium payments.
- Information Disclosed:
- We may provide Confidential Information to You in order to supply You with information about Your Benefits, or if You request to inspect Your Confidential Information.
- We may provide Your Confidential Information to health care providers and to Our business associates who request Confidential Information for payment-related activities and for health care operations.
- We may provide Your Confidential Information to someone who has the legal right to act on Your behalf.
- We may provide Confidential Information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.
- We may provide Confidential Information without Your written permission for matters in the public interest such as public health and safety activities or averting a serious threat to the health or safety of others.
- We may provide Confidential Information that We collect to third-parties involved in the underwriting, processing, servicing and marketing of Your Paramount Dental insurance products. We will not provide this information to any other third party for purposes other than set forth above unless We have a written agreement that requires such third party to protect the confidentiality of this information or Your written authorization.

- The law or the courts may require Us to provide Confidential Information to persons or agencies involved in regulatory, enforcement, or civil or criminal judicial activities.
- When We provide Your Confidential Information to any third party, We will provide only a limited data set, or if needed, the minimal amount of information that We deem is necessary.
- We do not disclose any Confidential Information about Our customers to anyone except as permitted or required by law.
- We must obtain Your written authorization for any disclosures of Your Confidential Information for purposes other than those listed above, including disclosures of psychotherapy notes or for marketing purposes.
- We are prohibited from using or disclosing genetic information of an individual for underwriting purposes.

Security of Your Confidential Information:

- Access of Your Confidential Information is available from Us only to persons involved in underwriting, processing information, marketing company products, or providing dental care for Your benefit. Access must be granted to those entities to enable them to provide the excellent service You have come to expect from Paramount Dental.
- We maintain physical, electronic, and procedural safeguards that comply with state and federal standards to guard Your Confidential Information.
- If We become aware that an item of Confidential Information may be materially inaccurate, We will make a reasonable effort to confirm its accuracy and correct any error as appropriate.
- If We believe Your Confidential Information has been breached, You will receive a written notification of the suspected breach.

Individual Rights:

- You have a right to learn about the nature and substance of any Confidential Information Paramount Dental has in its files about You. We reserve the right to charge a reasonable cost-based fee for copying and postage.
- You have the right to an accounting of certain disclosures of Your Confidential Information.
- You have the right to request that We place restrictions on the way We use and disclose Your Confidential Information. We will inform You within thirty (30) days of Our decision concerning Your request. We will agree to any request to restrict the disclosure of Your Confidential Information if the disclosure is for carrying out payment or health care operations and You have paid the provider in full out of Your pocket.
- You have a right to inspect Your Confidential Information and request that We amend it in Our files.
- You have a right to obtain a copy of Your Confidential Information that We use or maintain in an electronic health record. We reserve the right to charge a reasonable cost-based fee to provide such information to You or Your specific designee.
- Individual Enrollees who believe that the way we communicate decisions related to payment and Benefits may endanger their Confidential Information may request that We communicate with them using a reasonable alternative means or location.

Duties:

- Paramount Dental is required to abide by the terms of this Notice, and reserves the right to change the terms of this Notice at any time, provided that applicable law permits such changes. These revised practices will apply to Your Confidential Information regardless of when it was created or received. Before We make a material change to Our privacy practices, We will provide You with a revised Notice of Privacy Practices.
- Where multiple state or federal laws protect the privacy of Your Confidential Information, We will follow the requirements that provide the greatest privacy protection.

Further information:

If You need more information about Our privacy policy, or are concerned that We may have violated Your privacy rights, please contact Paramount Dental's Privacy Officer.

You may also submit a written complaint to:
Attn: Region
V, Office of Civil Rights
U.S. Dept. of Health and Human Services 233 N.
Michigan Ave, Ste 240
Chicago, IL 60601
Voice mail: 312.866.2359
Fax: 313.866.1807

We support Your right to protect the privacy of Your Confidential Information. We will not take action against You.

Physical Examinations and Autopsy

We reserve the right, at our own expense, to examine a Member when and as often as may be reasonably required for the determination of a claim. We may request an autopsy in case of death where it is not forbidden by law.

ERISA

As a participant in a Paramount Dental plan, You may be entitled to certain rights and protections under ERISA. You should check with Your employer to determine whether ERISA applies in Your situation. If You are covered by ERISA, then You may:

- Obtain the Plan Administrator's name, address, and telephone number from Your employer.
- Examine (without charge) at the Plan Administrator's office and at certain other locations, all plan documents, including the group insurance contracts, and copies of all documents filed by the Plan Administrator with the Internal Revenue Service such as annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- Receive a Summary Annual Report (SAR), Summary Plan Description (SPD) and a Summary of Material Modifications (SMM).
- Receive a written explanation if Your Claim for Benefits has been denied. You have the right to request a review of any such denial. If Your Claim is still denied, You may sue for Your Benefits.
- File suit in Federal court if materials You requested aren't received within thirty (30) days (unless the materials weren't sent because of matters beyond the administrator's control), or if You feel Benefits have been improperly denied, or if You have been discriminated against exercising Your rights under ERISA. If You are successful, the court may require the administrator to provide the materials You requested and pay up to $110 a day until You receive them. The court will decide who should pay the court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim frivolous.

First, consult Paramount Dental or Your employer to be certain You thoroughly understand the dental Benefits coverage and Claims procedures. If, after following all procedures, satisfactory resolution has not been reached, You may wish to contact the appropriate state department of Insurance or the United States Department of Labor for assistance. Your exercise of any rights under ERISA will not adversely affect Your employment status or plan benefits.

Grace Period

A grace period of thirty-one (31) days will be allowed for the payment of each Premium due after the first Premium. This coverage will remain in effect during the grace period unless the Employer has given advance written notice of discontinuance of coverage.

Notification to Insureds

Paramount Dental will notify the Employer in writing by mail to the Employer's last known address at least thirty (30) days prior to the Effective Date of the termination of Your insurance, a change in Your Premium, a change in Eligibility or a change in Your Benefits. This notice will also be provided to You, the agent, and the Plan Administrator, if any.

Misstatement of Age

If the age of any individual covered under the Policy has been misstated, all amounts payable under this policy shall be such as the Premium paid would have purchased at the correct age.

Incontestability

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

After the Policy has been in force for three (3) years, We will not use any statements made in the application of the Employer to void the Policy. After You have been covered under the Policy for three (3) years, We will not use any statement made in Your enrollment form to defend a Claim.

Conformity with State Statutes

If any provisions of the Plan is contrary to any law to which it is subject, such provision will be amended to conform to the minimum extent necessary to satisfy legal requirements.
Questions regarding your policy or coverage should be directed to:

Paramount Dental
P.O. Box 659 Evansville, IN 47704-0659
800.727.1444 press 9
7:30 am – 5:00 pm CST Monday through Friday

If You (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: 1-800-622-4461 / (317) 232-239
Complaints can be filed electronically at www.in.gov/idoi.

Benefit Details

ADA Code	Service Description	In/Out %
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	100/100
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	100/100
D0145	ORAL EVALUATION FOR A PATIENT UNDER 3 YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	100/100
D0150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	100/100
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	100/100
D0170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT NOT POST-OPERATIVE VISIT)	100/100
D0180	COMPREHENSIVE PERIODONTAL EVALUATION-NEW OR ESTABLISHED PATIENT	100/100
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	100/100
D0220	INTRAORAL-PERIAPICAL FIRST RADIOGRAPHIC IMAGE	100/100
D0230	INTRAORAL-PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	100/100
D0240	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE	100/100
D0270	BITEWING-SINGLE RADIOGRAPHIC IMAGE	100/100
D0272	BITEWINGS-TWO RADIOGRAPHIC IMAGES	100/100
D0273	BITEWINGS-THREE RADIOGRAPHIC IMAGES	100/100
D0274	BITEWINGS-FOUR RADIOGRAPHIC IMAGES	100/100

Benefit Details

ADA Code	Service Description	In/Out %
D0277	VERTICAL BITEWINGS-7 TO 8 RADIOGRAPHIC IMAGES	100/100
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	100/100
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES BY REPORT	100/100
D0330	PANORAMIC RADIOGRAPHIC IMAGE	100/100
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE ACQUISITION, MEASUREMENT AND ANALYSIS	100/100
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES OBTAINED INTRAORALLY OR EXTRAORALLY	100/100
D0460	PULP VITALITY TESTS	100/100
D0470	DIAGNOSTIC CASTS	100/100
D0701	PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0702	2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0703	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY – IMAGE CAPTURE ONLY	100/100
D0706	INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0707	INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0708	INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY	100/100
D0709	INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY	100/100
D1110	PROPHYLAXIS-ADULT	100/100

Benefit Details

ADA Code	Service Description	In/Out %
D1120	PROPHYLAXIS-CHILD	100/100
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	100/100
D1208	TOPICAL APPLICATION OF FLUORIDE- EXCLUDING VARNISH	100/100
D1351	SEALANT-PER TOOTH (PERMANENT MOLAR TEETH)	100/100
D1510	SPACE MAINTAINER-FIXED, UNILATERAL - PER QUADRANT	100/100
D1516	SPACE MAINTAINER-FIXED-BILATERAL,MAXILLARY	100/100
D1517	SPACE MAINTAINER-FIXED-BILATERAL,MANDIBULAR	100/100
D1520	SPACE MAINTAINER - REMOVABLE - UNILATERAL - PER QUADRANT	100/100
D1526	SPACE MAINTAINER-REMOVABLE-BILATERAL,MAXILLARY	100/100
D1527	SPACE MAINTAINER-REMOVABLE-BILATERAL,MANDIBULAR	100/100
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MAXILLARY	100/100
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER - MANDIBULAR	100/100
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER - PER QUADRANT	100/100
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED, UNILATERAL - PER QUADRANT	100/100
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	50/50
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	50/50
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	50/50
D2330	RESIN-BASED COMPOSITE-ONE SURFACE, ANTERIOR	50/50
D2331	RESIN-BASED COMPOSITE-TWO SURFACES, ANTERIOR	50/50
D2332	RESIN-BASED COMPOSITE-THREE SURFACES, ANTERIOR	50/50
D2335	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES (ANTERIOR)	50/50
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR (PRIMARY ONLY)	50/50
D2391	RESIN-BASED COMPOSITE-ONE SURFACE, POSTERIOR	50/50
D2392	RESIN-BASED COMPOSITE-TWO SURFACES, POSTERIOR	50/50
D2393	RESIN-BASED COMPOSITE-THREE SURFACES, POSTERIOR	50/50
D2394	RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES, POSTERIOR	50/50
D2520	INLAY-METALLIC-TWO SURFACES	50/50
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	50/50
D2542	ONLAY-METALLIC-TWO SURFACES	50/50
D2543	ONLAY-METALLIC-THREE SURFACES	50/50
D2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	50/50
D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	50/50
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SURFACES	50/50
D2642	ONLAY-PORCELAIN/CERAMIC-TWO SURFACES	50/50
D2643	ONLAY-PORCELAIN/CERAMIC-THREE SURFACES	50/50
D2644	ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SURFACES	50/50
D2651	INLAY-RESIN-BASED COMPOSITE-TWO SURFACES	50/50
D2652	INLAY-RESIN-BASED COMPOSITE-THREE OR MORE SURFACES	50/50
D2663	ONLAY-RESIN-BASED COMPOSITE-THREE SURFACES	50/50
D2664	ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE SURFACES	50/50
D2710	CROWN-RESIN-BASED COMPOSITE (INDIRECT)	50/50
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	50/50
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	50/50
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50/50
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	50/50
D2753	CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D2780	CROWN-3/4 CAST HIGH NOBLE METAL	50/50
D2781	CROWN-3/4 CAST PREDOMINANTLY BASE METAL	50/50
D2782	CROWN-3/4 CAST NOBLE METAL	50/50
D2783	CROWN-3/4 PORCELAIN/CERAMIC	50/50
D2790	CROWN-FULL CAST HIGH NOBLE METAL	50/50
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	50/50
D2792	CROWN-FULL CAST NOBLE METAL	50/50
D2794	CROWN-TITANIUM AND TITANIUM ALLOYS	50/50
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	50/50
D2920	RE-CEMENT OR RE-BOND CROWN	50/50
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	50/50
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	50/50
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW (PRIMARY TOOTH)	50/50
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN-PRIMARY TOOTH	50/50
D2940	PROTECTIVE RESTORATION	50/50
D2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D2951	PIN RETENTION, PER TOOTH, IN ADDITION TO RESTORATION	50/50
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	50/50
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	50/50
D2960	LABIAL VENEER (RESIN LAMINATE) – DIRECT	50/50
D2962	LABIAL VENEER (PORCELAIN LAMINATE) – INDIRECT	50/50
D2971	ADDITIONAL PROCEDURES TO CUSTOMIZE A CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK	50/50
D2975	COPING	50/50
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)-REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT	50/50
D3230	PULPAL THERAPY (RESORBABLE FILLING)-ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	50/50
D3240	PULPAL THERAPY (RESORBABLE FILLING)-POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	50/50
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	50/50
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)	50/50
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	50/50
D3351	APEXIFICATION/RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	50/50
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION, ETC)	50/50
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY-APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D3410	APICOECTOMY-ANTERIOR	50/50
D3421	APICOECTOMY-BICUSPID (FIRST ROOT)	50/50
D3425	APICOECTOMY - MOLAR (FIRST ROOT)	50/50
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	50/50
D3430	RETROGRADE FILLING-PER ROOT	50/50
D3450	ROOT AMPUTATION-PER ROOT	50/50
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY	50/50
D3950	CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST	50/50
D4210	GINGIVECTOMY OR GINGIVOPLASTY-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	50/50
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	50/50
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	50/50
D4261	OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)-ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	50/50
D4266	GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE	50/50
D4267	GUIDED TISSUE REGENERATION, NATURAL TEETH – NON-RESORBABLE BARRIER, PER SITE	50/50
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	50/50
D4273	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)	50/50
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	50/50
D4277	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT	50/50
D4278	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	50/50
D4283	AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	50/50
D4285	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT SURGICAL SITE AND DONOR MATERIAL)-EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE	50/50
D4341	PERIODONTAL SCALING AND ROOT PLANING-FOUR OR MORE TEETH PER QUADRANT (4 TEETH WITH 4+MM POCKETS)	50/50
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT	50/50
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION - FULL MOUTH, AFTER ORAL EVALUATION	50/50
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	50/50
D4910	PERIODONTAL MAINTENANCE	50/50
D5110	COMPLETE DENTURE-MAXILLARY	50/50
D5120	COMPLETE DENTURE-MANDIBULAR	50/50
D5130	IMMEDIATE DENTURE-MAXILLARY	50/50
D5140	IMMEDIATE DENTURE-MANDIBULAR	50/50
D5211	MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	50/50
D5213	MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5214	MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE-RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)	50/50
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	50/50
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)	50/50
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	50/50
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	50/50
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)	50/50
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	50/50
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	50/50
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	50/50
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5630	REPAIR OR REPLACE BROKEN CLASP-PER TOOTH	50/50
D5640	REPLACE BROKEN TEETH-PER TOOTH	50/50
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	50/50
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	50/50
D5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	50/50
D5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	50/50
D5710	REBASE COMPLETE MAXILLARY DENTURE	50/50
D5711	REBASE COMPLETE MANDIBULAR DENTURE	50/50
D5720	REBASE MAXILLARY PARTIAL DENTURE	50/50
D5721	REBASE MANDIBULAR PARTIAL DENTURE	50/50
D5730	RELINE COMPLETE MAXILLARY DENTURE (DIRECT)	50/50
D5731	RELINE COMPLETE MANDIBULAR DENTURE (DIRECT)	50/50
D5740	RELINE MAXILLARY PARTIAL DENTURE (DIRECT)	50/50
D5741	RELINE MANDIBULAR PARTIAL DENTURE (DIRECT)	50/50
D5750	RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	50/50
D5751	RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D5760	RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)	50/50
D5761	RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)	50/50
D5820	INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY	50/50
D5821	INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR	50/50
D5850	TISSUE CONDITIONING, MAXILLARY	50/50
D5851	TISSUE CONDITIONING, MANDIBULAR	50/50
D5863	OVERDENTURE-COMPLETE MAXILLARY	50/50
D5864	OVERDENTURE-PARTIAL MAXILLARY	50/50
D5865	OVERDENTURE-COMPLETE MANDIBULAR	50/50
D5866	OVERDENTURE-PARTIAL MANDIBULAR	50/50
D6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	50/50
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	50/50
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)	50/50
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	50/50
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	50/50
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	50/50
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	50/50
D6066	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	50/50
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	50/50
D6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	50/50
D6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)	50/50
D6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)	50/50
D6071	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	50/50
D6072	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	50/50
D6073	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL)	50/50
D6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	50/50
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	50/50
D6076	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	50/50
D6077	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	50/50
D6082	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	50/50
D6083	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6084	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6086	IMPLANT SUPPORTED CROWN - PREDOMINANTLY BASE ALLOYS	50/50
D6087	IMPLANT SUPPORTED CROWN - NOBLE ALLOYS	50/50
D6088	IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	50/50
D6092	RE-CEMENT RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN	50/50
D6094	ABUTMENT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	50/50
D6097	ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6098	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	50/50
D6099	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS	50/50
D6110	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MAXILLARY	50/50
D6111	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH-MANDIBULAR	50/50
D6112	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY	50/50
D6113	IMPLANT / ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR	50/50
D6114	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MAXILLARY	50/50
D6115	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH-MANDIBULAR	50/50
D6116	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MAXILLARY	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6117	IMPLANT / ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH-MANDIBULAR	50/50
D6120	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6194	ABUTMENT SUPPORTED RETAINER CROWN FOR FPD - TITANIUM AND TITANIUM ALLOYS	50/50
D6195	ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6210	PONTIC-CAST HIGH NOBLE METAL	50/50
D6211	PONTIC-CAST PREDOMINANTLY BASE METAL	50/50
D6212	PONTIC-CAST NOBLE METAL	50/50
D6214	PONTIC-TITANIUM AND TITANIUM ALLOYS	50/50
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	50/50
D6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50/50
D6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	50/50
D6243	PONTIC - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6245	PONTIC-PORCELAIN/CERAMIC	50/50
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	50/50
D6548	RETAINER-PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS	50/50
D6740	RETAINER CROWN - PORCELAIN/CERAMIC	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D6750	RETAINER CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	50/50
D6751	RETAINER CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	50/50
D6752	RETAINER CROWN - PORCELAIN FUSED TO NOBLE METAL	50/50
D6753	RETAINER CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	50/50
D6780	RETAINER CROWN - 3/4 CAST HIGH NOBLE METAL	50/50
D6781	RETAINER CROWN - 3/4 CAST PREDOMINANTLY BASE METAL	50/50
D6782	RETAINER CROWN - 3/4 CAST NOBLE METAL	50/50
D6783	RETAINER CROWN - 3/4 PORCELAIN/CERAMIC	50/50
D6784	RETAINER CROWN 3/4 - TITANIUM AND TITANIUM ALLOYS	50/50
D6790	RETAINER CROWN - FULL CAST HIGH NOBLE METAL	50/50
D6791	RETAINER CROWN - FULL CAST PREDOMINANTLY BASE METAL	50/50
D6792	RETAINER CROWN - FULL CAST NOBLE METAL	50/50
D6794	RETAINER CROWN - TITANIUM AND TITANIUM ALLOYS	50/50
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	50/50
D6940	STRESS BREAKER	50/50
D7111	EXTRACTION, CORONAL REMNANTS-DECIDUOUS TOOTH	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	50/50
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	50/50
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	50/50
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	50/50
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	50/50
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	50/50
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	50/50
D7251	CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY	50/50
D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH	50/50
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	50/50
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	50/50
D7284	EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS	50/50
D7286	INCISIONAL BIOPSY OF ORAL TISSUE-SOFT	50/50
D7291	TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT	50/50
D7310	ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	50/50
D7311	ALVEOLOPLASTY IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D7320	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT	50/50
D7321	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS-ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	50/50
D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	50/50
D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)	50/50
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	50/50
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	50/50
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER UP TO 1.25 CM	50/50
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR-LESION DIAMETER GREATER THAN 1.25 CM	50/50
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	50/50
D7472	REMOVAL OF TORUS PALATINUS	50/50
D7473	REMOVAL OF TORUS MANDIBULARIS	50/50
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	50/50
D7511	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)	50/50
D7830	MANIPULATION UNDER ANESTHESIA	50/50
D7922	PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN THE HEMOSTASIS OR CLOT STABILIZATION, PER SITE	50/50
D7961	BUCCAL / LABIAL FRENECTOMY (FRENULECTOMY)	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	50/50
D7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH	50/50
D7971	EXCISION OF PERICORONAL GINGIVA	50/50
D7980	SIALOLITHOTOMY	50/50
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	50/50
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	50/50
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	50/50
D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION	50/50
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	50/50
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	50/50
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	50/50
D8210	REMOVABLE APPLIANCE THERAPY	50/50
D8220	FIXED APPLIANCE THERAPY	50/50
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT	50/50
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15 MINUTES	50/50
D9223	DEEP SEDATION/GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT	50/50

Benefit Details

ADA Code	Service Description	In/Out %
D9230	INHALATION OF NITROUS OXIDE/ANALGESIA, ANXIOLYSIS (PER VISIT)	50/50
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA - FIRST 15 MINUTES	50/50
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT	50/50
D9944	OCCLUSAL GUARD-HARD APPLIANCE, FULL ARCH	50/50
D9945	OCCUSAL GUARD-SOFT APPLIANCE, FULL MOUTH	50/50
D9946	OCCLUSAL GUARD-HARD APPLIANCE,PARTIAL ARCH	50/50
D9973	EXTERNAL BLEACHING-PER TOOTH	50/50
D9974	INTERNAL BLEACHING-PER TOOTH	50/50
D9995	TELEDENTISTRY – SYNCHRONOUS - REAL-TIME ENCOUNTER	100/100

Plan General Exclusions, Limitations and Restrictions

Including provider supporting documentation requirements.

Eligibility is determined by the last date(s) of service and not based on a calendar or plan year. The last date(s) of service are determined by the prior completion date(s) in which the enrollee was eligible to receive benefits. Covered services for which a patient is not eligible, may be billed to the patient. Covered services that are disallowed by the plan, may not be billed to the patient.

ADA Range	Limitations/Exclusions
D0120, D0145, D0160, D0170	Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0140	An evaluation limited to a specific oral health problem or complaint. The use of this procedure code is also appropriate in dental emergencies, trauma, acute infection, etc. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0150, D0180	Eligible only once every 4 years. D0180 applies to age 14 and above. Evaluations - Not eligible for more than two evaluations, of any procedure code combination, within any consecutive 12 month period.
D0210, D0709	A complete series includes bitewings. Eligible only once per 4 years. Not eligible if performed within 4 years of D0330, D0701 or D0709. If D0210 is performed within 12 months of D0270, D0272, D0273, D0274, D0708 the allowable amount for D0210 will be reduced by the charges for D0270, D0272, D0273, D0274, D0708. Not eligible if performed within 12 months of D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0220, D0230, D0707	Eligible for a maximum of 3 during a 12 month period. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0240	Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0706. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0270, D0708	"Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210, D0277 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.

ADA Range	Limitations/Exclusions
D0272, D0273	Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277.
D0274	"Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee. "Bitewing" radiographic images are limited to a maximum of 4 in a 12 month period. Not eligible if performed within 12 months of D0210 or D0277.
D0277	Not eligible if performed within 12 months of D0210 or D0274. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0320, D0321	Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0330, D0701	Eligible only once per 4 years. Not eligible if performed within 4 years of D0210, D0701 or D0709. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D0340	Eligible only once per 2 years. Not eligible if performed within 2 years of D0702. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0350, D0703	Eligible only once per 5 years. Not eligible if performed within 4 years of D0703. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0460	Eligible for one charge per date of service.
D0470	Eligible only once per 5 years. It is included in the charges for complete or partial dentures, separate charges are disallowed. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.

ADA Range	Limitations/Exclusions
D0702	Eligible only once per 2 years. Not eligible if performed within 2 years of D0340. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D0706	Eligible only once per arch per 12 months. Not eligible if performed within 12 months of D0240. Radiographs - The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a D0210. The difference may not be billed to the Enrollee.
D1110, D1120	Not eligible for more than 2 cleanings per 12 consecutive month period which includes utilization of codes D4341, D4346, D4355, or D4910. Reimbursement for D1120 is limited to enrollees under the age of 14.
D1206	Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Eligible only for children under 14 years of age.
D1208	Not eligible for more than 2 fluoride treatments per 12 consecutive month period. Age limitation may apply.
D1351	Eligible on permanent molar teeth (per tooth) only. Not eligible for replacement for a period of 5 years. Eligible only for children under 15 years of age. Not eligible for a restoration on the O, OB, or OL surfaces following the placement of a sealant on that surface or if a restoration involving the O surfaces has been performed for a period of 3 years.
D1510, D1516, D1517, D1520, D1526, D1527, D1575	Eligible only for children under 13 years of age. Not eligible if performed within 3 years of D1510, D1515, D1520, D1525, or D1575.
D1551, D1552, D1553	Not eligible within 12 months of the initial placement of the space maintainer. Eligible once per 12 months.
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394	Not eligible for the replacement of or an additional restoration on the same surface for a period of 2 years. Not eligible if performed within 3 years of placing a crown on the same tooth or a sealant on the same surface within 3 years. If two or more restorations are performed on the same tooth, on the same date of service, only the total number of unique surfaces will be considered.

ADA Range	Limitations/Exclusions
D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2651, D2652, D2663, D2664, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794	Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2710	Eligible on anterior teeth only. Not eligible for a replacement by any type of inlay, onlay, or crown for 5 years. A charge for a crown following the placement of a restoration is not eligible for a period of 3 years (a courtesy adjustment may be applied). Crowns, other than prefabricated steel crowns, are not eligible for primary teeth. Composite/resin inlays must be laboratory processed.
D2910, D2920, D6092	Not eligible for the recementation of an inlay, onlay, or crown within 12 months of the original cementation. Eligible once per 12 months.
D2930, D2931, D2933, D2934	Charges are subject to the same restrictions and conditions as D2520 through D2794.
D2940	Not eligible for replacement by another protective restoration for a period of 3 years. Not eligible if performed in conjunction with endodontics, an amalgam/composite restoration, inlay, onlay, crown, or fixed prosthesis retainer prepared or cemented at the same appointment. Charges for definitive treatment are subject to an adjustment if performed within 12 months of D2940.
D2950	Not eligible within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for core buildups requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo that substantiates one of the following three criteria: 1) more than 50% of the tooth crown is missing due to fracture or decay; 2) less than 3 mm of sound tooth structure remaining around the gum line; 3) previous root canal filling completed except where a prior crown through which the access is made remains on the tooth. Charges not meeting established criteria will be disallowed.
D2951	Charge is per tooth and limited to posterior teeth only. Additional pins will be disallowed.
D2952, D2954	Not eligible if performed within 7 years of D2950, D2952, or D2954. Eligible once per 7 years per tooth. Not allowable without history of root canal therapy.
D2960	Not eligible for a replacement for 3 years. Placement is restricted to anterior permanent teeth only.

ADA Range	Limitations/Exclusions
D2962	Not eligible for a replacement for 7 years. Placement is restricted to anterior permanent teeth only. Charges for veneered crowns replacing labial veneers (porcelain) are not allowable for 7 years.
D3220	Eligible for primary teeth only and only once per tooth. Charges are exclusive of the final restoration charge.
D3230	Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3240	Eligible on primary posterior teeth only. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. Separate fees for radiographs are disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3310, D3320, D3330	Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3351, D3352, D3353	Limited to children under 16 years of age. Eligible once per lifetime. Services are coded by the tooth receiving treatment, not the number of canals per tooth. Not eligible for retreatment within 4 years of the date of the original treatment. A single periapical will be considered however, fees for any additional radiographs will be disallowed. Charges are exclusive of the final restoration charge. Charges for "elective" root canal therapy, procedure completed to aid in the delivery of a more specialized procedure, may be deducted from the final restorative treatment.
D3410, D3421, D3425, D3426, D3430, D3450, D3920	Eligible once per lifetime.
D3950	Eligible once per 7 years. Charges will be disallowed if submitted in conjunction with D2952, D2953, D2954, or D2957.
D4210, D4260, D4261	Eligible only once per area treated for a 5 year period.

ADA Range	Limitations/Exclusions
D4249	Eligible only once on a per tooth basis. Eligible only once per tooth per lifetime.
D4266, D4267	Charges include the charge for the barrier, and its removal, if necessary. Eligible only once per area treated for a 5 year period.
D4270, D4273, D4275, D4277, D4278	Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site. Eligible only once per area treated for a 5 year period.
D4274	Eligible only when this procedure is performed in an edentulous area adjacent to a periodontally involved tooth. The tooth and proximal area must be identified. Eligible only if no additional surgery is performed in the immediate area, eligible every 5 years. Eligible only once per area treated for a 5 year period.
D4283, D4285	Two soft tissue grafts of any type are eligible per quadrant every 5 years. Teeth #24-25 are considered one site.
D4341	Eligible per quadrant (4 or more active periodontal diseased and qualified teeth). The enrollee must exhibit pocket depths of at least 4 mm around at least 4 teeth in each quadrant to qualify for coverage for this procedure. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements.
D4342	Eligible per quadrant (1 to 3 active periodontal diseased and qualified teeth). The enrollee must exhibit periodontal disease showing loss of clinical attachment and bone loss. Otherwise refer to D1110 and D4355. Not eligible on deciduous teeth. Not eligible for retreatment of any quadrant for 3 years. Charges require the submission of full mouth probe chart with six points per tooth probings AND diagnostic full mouth radiographs and/or vertical bitewings. Only two quadrants are considered on the same date of service, additional quadrants will be disallowed. Separate charges for local anesthetic are disallowed. A D1110 cannot be charged within 6 months if 4 quadrants of D4341/D4342 are performed. Charges not meeting established criteria will be disallowed. A pretreatment is suggested. Dental Review Team maintains discretionary authority regarding review requirements.
D4346	Eligible only for enrollees over 15 years of age. Eligible once per 5 years. Not eligible within 6 months of or same date of service as D1110, D1120, D4341/D4342 (quadrant allottment may apply), D4355, or D4910.
D4355	Eligible only for enrollees over 15 years of age. To be eligible, procedure must be performed before and not on the same date of service as D1110, D4341, D4342, D4346, or D4910, or more than 3 years has lapsed since D1110, D4341, D4342, D4346, D4355, or D4910 was performed.

ADA Range	Limitations/Exclusions
D4910	Not eligible if performed within 6 months of or same date of service as D1110, D1120, D4341/D4342 if four quadrants were treated, D4346 or D4355. Not eligible for more than 2 per 12 consecutive month period. Eligible only for enrollees over 15 years of age.
D5110, D5120	Not eligible for the replacement of a denture, including an immediate or partial denture, within 7 years. Separate charges for diagnostic casts (D0470) are disallowed. Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch or of any repairs, relines, rebases (D5510 through D5761).
D5130, D5140	An immediate denture cannot be used to replace a complete denture. Other restrictions are the same as D5110 & D5120.
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226	Eligible every 7 years and are subject to the same conditions and restrictions listed for D5110 & D5120. Separate charges for diagnostic casts (D0470) are disallowed. The teeth replaced by the appliance must be identified on the claim form.
D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660	Not eligible if the procedure is performed within 6 months of the date of delivery of the appliance. Eligible once per procedure code per 6 months.
D5670, D5671	Eligible only once per 4 years per prosthesis. Not eligible if performed within 4 years of D5213 or D5214. Not eligible for charges for rebase, reline or repairs for 6 months.
D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	Not eligible within 6 months of the date of delivery of the appliance except when an immediate partial/denture is performed. Eligible for any of these procedures only once per 4 years per prosthesis.
D5820, D5821	Charges for a conventional, removable partial dentures or a complete denture (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5225, and D5226) are subject to an adjustment if performed within 5 years of an interim partial denture (D5820 & D5821) in the same arch.
D5850, D5851	Eligible for two tissue conditioning charges within 6 months of delivery of immediate partial/denture only.

ADA Range	Limitations/Exclusions
D5863, D5864, D5865, D5866	Charges are subject to the conditions listed for D5110/D5120 and D5213/D5214.
D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6194, D6195	Charges are subject to the same definitions and restrictions listed for D2710 thru D2794 and D6210 thru D6974. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.
D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117	Charges are subject to the same definitions and restrictions listed for D5110 thru D5866. All implant supported services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch.
D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6545, D6548, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794	Charges are subject to the same definitions and restrictions listed for D2520 thru D2794. Each unit of a fixed partial denture must be identified on the claim. Not eligible for pontics to replace third molars. All fix prosthodontic services are subject to an adjustment if performed within 5 years of an interim partial denture in the same arch. Not eligible for replacement of a removable partial denture by a fixed partial denture within 7 years of the original placement.
D6930	Not eligible within 12 months of the original cementation. Eligible only once per 12 months per fixed partial denture.
D7210, D7250	Surgical extractions: use when either (1) removal of bone and/or (2) sectioning of tooth, including elevation of mucoperiosteal flap if indicated, is necessary. Surgical extraction charges include alveoloplasty. Primary teeth, teeth 7-10 and 23-26 require the submission of a duplicate, diagnostically acceptable, pre-operative periapicial and/or panoramic radiograph with claim submission. Charges not meeting established criteria will be disallowed.
D7280, D7283	Eligible once per lifetime. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.
D7284, D7286	Charges will be disallowed in performed in conjunction with D3410, D3421, D3425, D3426, or D3427.
D7291	Eligible on anterior permanent teeth and bicuspids. Eligible only if the procedure is performed in conjunction with an orthodontic benefit rider and treatment.

ADA Range	Limitations/Exclusions
D7310, D7311	Charges are subject to review if performed in conjunction with D7210 thru D7250. Charges not meeting generally accepted standards of care will be disallowed (see D7210 thru D7250).
D7340, D7350	Charges filed in conjunction with implant services will be disallowed.
D7473	Eligible once per arch per lifetime.
D7510	Charges filed in conjunction with definitive treatment will be disallowed.
D7922	Not eligible for more than a combination of two D7922 or D9110 per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.
D7961, D7962	Eligible once per lifetime. Charges are subject to review if performed in conjunction with definitive treatment. Charges not meeting generally accepted standards of care will be disallowed.
D7971	Charges filed in conjunction with definitive restorative treatment will be disallowed.
D9110	Not eligible for more than two palliative (emergency) treatments per 12 month period. Charges filed in conjunction with definitive treatment will be disallowed.
D9222, D9223, D9239, D9243	Limited to a total of 30 minutes per date of service.

ADA Range	Limitations/Exclusions
D9230	Eligible once per date of service.
D9944, D9945, D9946	Occlusal guards are removable dental appliances designed to minimize the effects of bruxism and other occlusal factors. Eligible once every 5 years. Charges to modify the appliance or for occlusal adjustment are not eligible.
D9973	Eligible on anterior teeth only. Not eligible for retreatment within 3 years of the date of the previous treatment series. Not eligible for home bleaching trays and procedures.
D9974	Eligible on anterior teeth only with history of root canal therapy. Not eligible for retreatment within 3 years of the date of the previous treatment series. Not eligible for home bleaching trays and procedures.
D9995	Eligible one per 12 months.

Orthodontic Benefit Rider

Covered Orthodontic Benefits

Not all plans include benefits for orthodontic treatment. Orthodontic benefits, if included in the dental plan, cover certain orthodontic services and follow certain administration policies as indicated below.

The Standard Plan benefit covers the following orthodontic services:

Limited Orthodontic Treatment	Interceptive Orthodontic Treatment
Comprehensive Orthodontic Treatment	Minor Treatment to Control Harmful Habits

1. The dentist providing orthodontic services must file an initial claim form on behalf of the member and identify when services began, the anticipated length of the treatment period and the total cost of the treatment plan.

2. The Plan will indicate which Plan members qualify for the benefit and/or to what age the member is covered. The Standard Plan benefit covers only dependent children to a certain age, regardless of any treatment that may be in progress. Some Plans also cover adults.

3. The Plan will indicate the payment cycle for which benefits are paid. The Standard Plan benefit payment cycle makes payments of equal installments directly to the dentist on a monthly basis over a period of 24 months. The member must be an active member and be in active treatment during the entire 24 months to receive the full lifetime orthodontic benefit. If the treatment period is less than 24 months, the member's benefit will be paid only over the active treatment period and the full benefit will not be realized. If a non- standard payment cycle is selected, such as over the course of the treatment plan designated with the original claim filing, the terms will be indicated in the Plan. In the event a treatment plan is not defined with the original claim filing, the plan payment cycle will default to 24 months.

4. Active treatment is defined as treatment requiring periodic visits resulting in the movement and retention of teeth.

5. The Plan will indicate the coinsurance percentage that the member is responsible for. The Plan coinsurance may be different based on whether the dentist is a participating network or out of network dentist/orthodontist.

6. The Plan will indicate the amount of the Lifetime Orthodontic Maximum Benefit. A lifetime maximum benefit is the maximum amount paid on behalf of a member during that member's lifetime, regardless of whether a previous employer or carrier paid for the services (subject to availability of claim's information). A member is responsible for the difference between the lifetime maximum and the dentist's fee.

7. Members enrolled after the placement of braces may be eligible to receive benefits for the treatment in progress. The Plan will only consider a benefit based on the remainder of the treatment plan and will require the dentist to submit a claim for the remaining treatment plan. The member's benefit will be paid only over the remaining active treatment period and the full benefit may not be realized.

8. The Orthodontic benefit does not include benefits for lost, stolen, repairs, re-cementation, or replacement retainers. The benefit does not cover the removal of appliances for reasons other than completion of treatment.

9. Orthodontic benefits are paid "monthly" over a period of time and at the designated Plan payment amount in effect at the inception of the member's Orthodontic treatment plan. Adjustments to monthly payments will be made if the Plan Lifetime Annual benefit changes (increases or decreased) during the course of an existing treatment plan. This adjustment will only affect Plans with the Standard Benefit feature. Plans that pay benefits over a treatment plan personal to that member will "lock in" at the inception of a member's treatment plan and will not adjust over the course of the treatment as long as the Plan covers an Orthodontic Benefit. No lump sum payments will be made for any reason.

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FOREST RIVER, INC.
WELFARE BENEFIT PLAN

TABLE OF CONTENTS

ARTICLE I

Introduction

Section 1.1 Purpose of Plan. Forest River, Inc. (the "Company") maintains the FOREST RIVER, INC. WELFARE BENEFIT PLAN (the "Plan") for the purpose of providing welfare benefits to its eligible employees.

Section 1.2 Effective Date; Plan Year. The Plan was originally established by the Company effective January 1, 2016 (the "Original Effective Date"). The "Effective Date" of the Plan, as amended and restated as set forth herein, is January 1, 2020. The provisions of the Plan only apply to an individual employed by the Company on or after the Effective Date. The rights and benefits, if any, of an employee whose employment with the Company terminated before the Effective Date will be determined in accordance with the terms of the Plan as of the date of his termination. The Plan is administered on the basis of a "Plan Year," which is the twelve-month period commencing on each January 1 and ending on the next following December 31.

Section 1.3 Plan Administration. The Plan will be administered by the Company or by a committee appointed by the Company (the "Administrator"). Except as provided in Article V, the Administrator will be the "plan administrator" and "named fiduciary" of the Plan. The Administrator may engage one or more third-party administrators to process benefit claims and to assist in the overall administration of the Plan. The Administrator, from time to time, may adopt any rules and procedures it deems necessary or desirable for the proper and efficient administration of the Plan. Any notice or document required to be given to or filed with the Company or the Administrator will be properly given or filed if delivered or mailed by registered mail, postage paid, to Forest River, Inc., P.O. Box 3030, 900 County Road 1, Elkhart, IN 46515-3030.

Section 1.4 Plan Benefit Arrangements and Policies. The Plan is funded by the Company through self-funded benefit arrangements (an "arrangement" or the "arrangements") and fully-insured group policies (a "policy" or the "policies") as described in Appendix A. An authorized officer can add, delete, or otherwise modify an arrangement or policy by amending the Appendix and any of the Supplements related to the Plan without a requirement to formally amend this Plan.

The terms and provisions of each arrangement and policy are attached hereto as supplements to the Plan and are hereby incorporated by reference into the Plan as provided in Section 1.5.

Section 1.5 Supplements. The provisions of the Plan may be modified by supplements to the Plan. The terms and provisions of each supplement are a part of the Plan and, unless prohibited by law, supersede any other provisions of the Plan to the extent necessary to eliminate any inconsistencies between the supplement and any other Plan provision.

Section 1.6 Employers and Affiliates. Any Affiliate may adopt the Plan for the benefit of its employees with the Company's consent in accordance with Section 8.1. For purposes of this Plan, the term "Affiliate" means the Company and any other corporation or trade or business within the same control group (as defined in ERISA Section 3(40)(B)). The Company and each other Affiliate that adopts the Plan are referred to as the "Employers" and sometimes individually as an "Employer."

ARTICLE II

Participation

Section 2.1 Commencement of Participation. Subject to the conditions and limitations of the Plan, an employee of the Company who is eligible for coverage under an arrangement or policy will be eligible to participate in the Plan. An employee will become a "Participant" in the self-funded benefit arrangements described in Section 1.4 in accordance with the terms and conditions of the applicable arrangement. An employee will become a "Participant" in the fully-insured benefit policies described in Section 1.4 in accordance with the terms and conditions specified in the applicable policy. A spouse or dependent of a Participant will become covered under the self-funded benefit arrangements described in Section 1.4 in accordance with the terms and conditions of the applicable arrangement. A spouse or dependent of a Participant will become covered under the fully-insured benefit policies described in Section 1.4 in accordance with the terms and conditions specified in the applicable policy. An employee and any dependent will become covered and will remain covered under an arrangement or policy at the time, for the periods and under the conditions specified in the applicable arrangement or policy.

Section 2.2 Cessation of Participation. Except as provided in Article IV, a Participant will cease to be a Participant, and a dependent will cease to be a covered dependent, eligible for benefits under this Plan on (and no benefits will be payable under the Plan after) the earliest of (i) the date he is no longer eligible for coverage under the terms of any arrangement or policy, as provided in the arrangement or policy (ii) the date the Plan is terminated or (iii) the date he ceases to make a contribution towards the cost of an arrangement or policy as required by the Administrator.

Section 2.3 Reinstatement of Former Participant. A former Participant whose employment with the Company terminates will be treated as a new employee on his rehire and will again become a Participant in accordance with Section 2.1. Notwithstanding the foregoing, a former Participant who has a break in service of less than 13 weeks will become eligible for coverage under the medical arrangement in accordance with the rules set forth in Section 2.1, without regard to his break in service.

Section 2.4 Notice of Participation. The Administrator will notify each employee of the date on which he becomes eligible to participate in the Plan, and will furnish each Participant and dependent receiving benefits under the Plan with a copy of a summary plan description.

Section 2.5 COBRA Continuation Provisions. A Participant, his spouse and his dependents will be eligible to continue their medical, pharmacy, dental and vision coverage (the "medical coverages") under the Plan to the extent provided by terms of Internal Revenue Code Section 4980B and Article IV.

ARTICLE III

Plan Benefits

Section 3.1 Benefit Amounts. A Participant and dependent will be covered under the arrangements and policies described in Section 1.4 as provided in Article II and, therefore, will be eligible for benefits only as set forth in the applicable arrangements and policies.

Section 3.2 Benefit Payments. To receive a benefit under this Plan, a Participant, or other person eligible for a benefit by reason of his relationship to a Participant, must submit a claim to the applicable third-party claims administrator or insurer under the terms of the applicable arrangement or policy. Benefit payments will be made by the third-party claims administrator or insurer as soon as practicable after a properly completed claim has been submitted and approved by the third-party claims administrator or insurer, consistent with applicable law. To be eligible for a benefit, the claim required by this Section must contain the information and materials required under the applicable arrangement or policy and must be filed with the third-party claims administrator or insurer within the period described in that arrangement or policy.

Section 3.3 Coordination of Benefits. Benefits payable under the Plan will be coordinated with benefits payable under other insurance, plan or HMO coverages in accordance with the terms of that arrangement or policy.

Section 3.4 Subrogation. Subject to applicable law and the provisions of the arrangement or policy described in Section 1.4, if benefits are paid or payable under the Plan to or on behalf of a Participant or a person eligible for a benefit by reason of his relationship to the Participant (a "dependent") and if the Participant or dependent (or the Participant's or dependent's guardian or estate) has, may have, or asserts a claim or right to recovery against any other party or parties (including insurance companies and carriers), the Plan will be subrogated to all claims and rights of recovery of the Participant or dependent and will be entitled to reimbursement from any judgment, settlement or payment resulting from the individual's claim or right. The Plan will be reimbursed in full for any benefits paid or payable by the Plan before any amounts (including legal fees incurred by the Participant or dependent or guardian or estate) are deducted from the judgment, settlement or payment or are paid to any other person (including the Participant or dependent). If a suit is filed, the Plan may record a notice of payment of benefits which will constitute a lien against any judgment recovered.

The Participant or dependent (including his or her guardian or estate) must take any action the Plan may reasonably require to secure the Plan's rights under this Section and avoid any action that would prejudice the Plan's rights. If the dependent is a minor, or under any other legal disability, the parent or guardian of the dependent may act on behalf of, and consequently bind, the dependent for purposes of this Section.

If the Participant or dependent (including his or her guardian or estate) fails to promptly bring suit against the third-party, the Plan may take any legal action it deems necessary or desirable against the third-party in its own name or in the name of the Participant or dependent to secure recovery. The Plan may retain benefits paid or to be paid and its court costs (including attorney fees) from any judgment, settlement or payment, with the balance, if any, to be paid to the Participant or dependent.

Section 3.5 Reimbursement. If the Plan pays any amount to any individual (including a Participant or dependent) or entity in excess of the amount it is required to pay, the Plan will be entitled to be reimbursed for the excess from that individual or entity. If a Participant or dependent has received a payment from a third-party for any benefit, the Plan may reduce its required payment by that amount.

ARTICLE IV

Continuation Coverage Rights

Section 4.1 Purpose. The purpose of this Article is to describe provisions relating to the rights of certain Participants and their dependents to elect to continue coverage under the Plan's medical coverages if, but for such election, a qualifying event (as defined in Section 4.2) would result in a Participant's or dependent's loss of coverage under the arrangements or policies.

Section 4.2 Qualifying Event. The term "qualifying event" means any of the following events which would result in the loss of coverage under the medical coverages (or for purposes of subsection (f), a substantial elimination of coverage within one year before or after the commencement of the proceeding) for a qualified beneficiary:

(a) The death of the Participant;

(b) The termination (other than by reason of gross misconduct) or retirement of the Participant, or a reduction of the Participant's hours of employment;

(c) The divorce or legal separation from the Participant;

(d) The Participant's becoming entitled to benefits under Title XVIII of the Social Security Act;

(e) A dependent child ceasing to be classified as a dependent of a Participant; or

(f) A proceeding in a case under Title 11, United States Code, involving the Company as the debtor in bankruptcy, but only if the Participant retired from the Company and continued as a Participant.

The term "qualified beneficiary" means a spouse or dependent child of a Participant who was a beneficiary under the medical coverages on the day before the qualifying event and a dependent child who is born to or placed for adoption with the Participant (before the dependent attained age 18) during the Participant's period of coverage under this Article IV. For purposes of subsection (b) above, that term also includes the Participant. For purposes of subsection (f), a loss of coverage will be deemed to have occurred in the event of a substantial elimination of coverage for the Participant who retired on or before the date of the substantial elimination or for the spouse (including a surviving spouse) or a dependent child of that Participant who was a covered dependent on the day before the substantial elimination.

Section 4.3 Notice of Right to Elect Continuation Coverage. Within 30 days of the occurrence of an event described in Section 4.2(a), (b) or (d), the Company will provide the Administrator written notice of that event. Within 14 days of its receipt of the Company's notice, or the receipt by the Administrator of a timely notice from a Participant, the Administrator will provide the Participant's dependents covered under the medical coverages at the time of such event and, if applicable, the Participant, with written notice of such person's

right to continuation of coverage pursuant to the terms of this Article. Notification made to the spouse or former spouse of a Participant will be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made. For purposes of this Section, "timely notice from a Participant" will mean the receipt by the Administrator from the Participant or dependent of written notification of the occurrence of an event described in subsection 4.2(c) or (e) within 60 days of the occurrence of such event.

Section 4.4 Election of Continuation Coverage. Subject to the conditions and limitations of this Article, a qualified beneficiary may make a written election of continuation of coverage under the medical coverages at any time during the 60-day period that begins on the later of (i) the date coverage would otherwise terminate under the medical coverages by reason of a qualifying event, or (ii) the date written notice of the right to continuation of coverage is provided to the qualified beneficiary; provided, however, that timely notice (as defined in Section 4.3) was received by the Administrator if continuation coverage is available as a result of a qualifying event described in subsection 4.2(c) or (e). For a qualifying event under subsection 4.2(b) or (f), the election of coverage may be made by the Participant, or may be made by the Participant's spouse. Such election will be deemed an election made on behalf of any other qualified beneficiary who would lose coverage as a result of that qualifying event. For a qualifying event under subsection 4.2(a), (c), (d) or (e), the election of coverage may be made solely by the spouse or former spouse of the Participant and such election will be deemed an election on behalf of any other qualified beneficiary who would lose coverage as a result of such death, divorce or legal separation; provided that, if one or more dependent children are the sole qualified beneficiaries under the medical coverages, the election may be made by (or on behalf of) such dependent children.

Section 4.5 Duration of Coverage. If continuation of coverage is elected within the election period described in Section 4.4, the coverage will be effective retroactively to the date coverage under the medical coverages would otherwise have terminated but for such election. Subject to the conditions and limitations of this Section, the maximum period for which coverage under the medical coverages may be continued following the occurrence of a qualifying event is as follows:

(a) In the case of a qualifying event under subsection 4.2(b), 18 calendar months following the date on which the qualifying event occurred; provided that, if (i) a subsequent qualifying event occurs during that 18 calendar month period of continuation coverage, the maximum period, for a qualified beneficiary other than the Participant, will not exceed a period of 36 calendar months measured from the date of the initial qualifying event or (ii) the Participant became entitled to benefits under Title XVIII of the Social Security Act within the 18-month period preceding the qualifying event under subsection 4.2(b), the maximum period, for a qualified beneficiary other than the Participant, will not exceed a period of 36 months measured from the date the Participant became entitled to that coverage. Notwithstanding the foregoing, in no event will a Participant's becoming entitled to benefits under Title XVIII of the Social Security Act be treated as a "subsequent qualifying event" under clause (i) of the preceding sentence.

(b) In the case of a qualifying event under subsection 4.2(b) for a qualified beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the qualifying event or during the first 60 days of coverage under this Article IV, 29 calendar months following the date of the qualifying event; provided that the qualified beneficiary has notified the Administrator within 60 days of the determination and prior to the end of the 18-month period described in (a) above.

(c) In the case of a qualifying event under subsection 4.2(f), the lifetime of the Participant for that Participant and 36 months following the death of the Participant for the surviving Dependents of that Participant.

(d) In all other cases, 36 calendar months following the date of the qualifying event.

Notwithstanding the foregoing, continuation of coverage pursuant to the provisions of this Article as to any qualified beneficiary will terminate upon the first to occur of the following events:

(1) Failure to make timely payment of the premium required under Section 4.7 of the Plan;

(2) Termination of the medical coverages (and all other group health plans maintained by the Company);

(3) Coverage under any other group health plan (as an employee or otherwise) obtained after the qualified beneficiary has elected continuation coverage, provided that the coverage does not contain any exclusion or limitation with respect to any preexisting condition, other than an exclusion or limitation that does not apply to (or is satisfied by) the qualified beneficiary;

(4) Entitlement to Medicare benefits under Title XVIII of the Social Security Act (other than for a qualified beneficiary described in the last sentence of Section 4.2); or

(5) The first day of the month beginning more than 30 days after the date a qualified beneficiary who was disabled and receiving coverage under subsection 4.5(b) is finally determined to no longer be disabled under Title II or XVI of the Social Security Act.

In the event a former Participant becomes entitled to Medicare benefits under Title XVIII of the Social Security Act during the 18-month period described in subsection 4.5(a), the maximum continuation for all the qualified beneficiaries other than the former Participant will be extended to 36 calendar months from the date of the initial qualifying event.

Section 4.6 Continuation Coverage. For purposes of this Article, "continuation coverage" means the coverage provided for under the medical coverages.

Section 4.7 Premium Requirement. As a condition of eligibility for continuation of coverage under this Article, a qualified beneficiary who elects to continue coverage (or on whose behalf such election is made) must make premium payments not less frequently than monthly in the amounts and at the times specified by the Administrator. The amount of such premium payments will be determined by the Administrator from time to time in accordance with the provisions of Section 4980B(f)(4) of the Internal Revenue Code. With respect to a qualified beneficiary whose election of continuation of coverage is made after the date of the qualifying event, the initial premium amount will take into account the period of coverage that precedes the date of election and must be paid in full no later than 45 days following the date of election. Subsequent premium payments will be considered timely made only if received by the Administrator no later than 30 days following the premium due date otherwise established by the Administrator and communicated to the qualified beneficiary; provided that no premium may be required prior to the expiration of the 45-day period described in the preceding sentence. Notwithstanding the foregoing, if the Participant's termination of employment was the result of a military leave covered by USERRA, the Participant's premium payment under this Section cannot be more than the normal premium amount for a similarly situated employee if the military leave was for 30 or fewer days.

Section 4.8 USERRA. An employee who is absent from work for more than 31 days in order to fulfill a period of duty in the "uniformed services" of the United States (as determined under the USERRA) will be treated as experiencing a qualifying event under Section 4.2(b) as of the first day of his absence for that duty. However, the maximum period of coverage under Section 4.5 will be the lesser of (i) 24 months following the date the qualifying event was deemed to occur or (ii) the period ending on the day after the date the employee fails to timely apply for or return to active employment with the Company following his discharge from active military duty.

Section 4.9 Waiver of Continuation Coverage. If the medical coverages so allow, a qualified beneficiary may waive his rights to continuation coverage under this Article at the time specified in Section 4.4 in a manner determined by the Administrator. The qualified beneficiary may revoke that waiver by electing continuation coverage at any time during the 60-day continuation coverage election period described in Section 4.4. The continuation coverage so elected will include any period before the election is made and after the date any of the events described in Section 4.2 have occurred. Coverage otherwise provided under this Article will not be made available effective as of the date such coverage would have been provided had the waiver been made and not revoked.

ARTICLE V

General Provisions

Section 5.1 Information Required by Administrator. Each person entitled to benefits under the Plan must furnish the Administrator or the applicable third-party claims administrator or insurer with any document, evidence, data or information the Administrator or applicable third-party claims administrator or insurer considers necessary or desirable for the purpose of administering the Plan or determining benefits. The records of the Company as to an employee's or Participant's period of employment, termination of employment and the reason therefore, reemployment and earnings will be conclusive on all persons unless determined to the Administrator's satisfaction to be incorrect.

Section 5.2 Uniform Rules. The Administrator will administer the Plan on a reasonable and nondiscriminatory basis and will apply uniform rules to all persons similarly situated.

Section 5.3 Benefit Determinations for Self-Funded Benefits. Benefits under a self-funded arrangement described in Section 1.4 will only be paid to the extent the third-party claims administrator for that arrangement determines benefits are payable. The third-party claims administrator for an arrangement will determine the timing and amount of payments, if any, to be made under the arrangement. A Participant or beneficiary may request a review of any determination made by a third-party claims administrator upon written request to that third-party claims administrator, who will be the named appeals fiduciary with respect to the arrangement. The claimant will be afforded a full and fair review of such a request. The review of that claim will be made in accordance with the procedures established by the third-party claims administrator for that purpose and in accordance with the regulations promulgated by the Department of Labor under the Employee Retirement Income Security Act of 1974 ("ERISA"), in accordance with regulations promulgated under the Patient Protection and Affordable Care Act ("PPACA"), if applicable. The procedures for review of a denied claim are fully set forth in the applicable arrangement, to the extent required by law. Furthermore, to the extent applicable a third-party claims administrator of a disability arrangement is responsible for adjudicating and reviewing claims in accordance with the disability claims regulations outlined in 29 CFR § 2540.502. To the extent that the disability administrator's benefit summary or booklet is inconsistent or incomplete, the Plan will comply with the disability claims regulations outlined in 29 CFR 2560.503.

Section 5.4 Review of Insured Benefit Determinations. Because the benefits under the group insurance policies described in Section 1.4 are only paid to the extent that the applicable insurer determines benefits are payable under a policy, the insurer will be the Plan's claims administrator and named appeals fiduciary with respect to the benefits provided under the policy it issued for the Plan. Consequently, the insurer will determine the timing and amount of payments, if any, to be made under the policy it issued and will afford a claimant a full and fair review of its determination in accordance with the claims and review procedures set by the insurer for the policy and any claims procedures applicable to the policy under regulations promulgated by the Department of Labor under ERISA, and in accordance with regulations promulgated under the PPACA, if applicable. The procedures for review of a denied claim are

fully set forth in the applicable policy or certificate, to the extent required by law. For the fully-insured disability policies, the insurer is responsible for adjudicating and reviewing claims in accordance with the disability claims regulations outlined in 29 CFR § 2540.502. To the extent that the disability insurer's policy or certificate is inconsistent or incomplete, the Plan will comply with the disability claims regulations outlined in 29 CFR 2560.503.

Section 5.5 Administrator Decision Final. The Administrator is empowered to, and will, interpret the Plan and decide all questions concerning the Plan and the eligibility of any person to participate in or benefit under the Plan, other than benefit claims determined by a claims administrator, appeals fiduciary (if someone other than the Administrator) under Section 5.3 or benefit claims determined by an insurer under Section 5.4. Any interpretation of the provisions of the Plan and any decisions on any matter made by the Administrator, a claims administrator, appeals fiduciary or insurer in good faith will be final and binding on all persons. Consequently, benefits under the Plan will be paid only if the Administrator or the applicable claims administrator, appeals fiduciary or insurer decides in its discretion that the applicant is entitled to them. When making a determination, the Administrator may rely upon information furnished by the Company, an employee, a claims administrator or the Company's legal counsel. A misstatement or other mistake of fact will be corrected when it becomes known and the Administrator will make such adjustment on account thereof as it considers equitable and practicable.

Section 5.6 Action by Company. Any action required or permitted to be taken by the Company under the Plan will be by resolution of its Board of Directors, Board of Managers or similar governing body, by resolution of a duly authorized committee of its Board of Directors, Board of Managers or similar governing body, or by a person or persons authorized by resolution of its Board of Directors, Board of Managers, similar governing body or such committee.

Section 5.7 Waiver of Notice. Any notice required under the Plan may be waived by the person entitled to such notice.

Section 5.8 Gender and Number. Where the context admits, words in the masculine gender will include the feminine and neuter genders, the singular will include the plural, and the plural will include the singular.

Section 5.9 Controlling Law. Except to the extent superseded by laws of the United States or as specifically provided otherwise in a policy or assignment, the laws of the State of Indiana will be controlling in all matters relating to the Plan.

Section 5.10 Employment Rights. The Plan does not constitute a contract of employment, and the participation in the Plan will not give any employee the right to be retained in the employ of the Company, or any right or claim to any benefit under the Plan, unless such right or claim has specifically accrued under the terms of the Plan.

Section 5.11 Interests Not Transferable. The interests of persons entitled to benefits under the Plan are not subject to their debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered.

Section 5.12 Facility of Payment. When a person entitled to a benefit under the Plan is under a legal disability, or, in the Administrator's opinion is in any way incapacitated so as to be unable to manage his financial affairs, the Administrator may direct benefit payments to be made to such person's legal representative, or to a relative or friend of such person for such person's benefit, or the Administrator may direct the application of such benefits for the benefit of such person. Any payment made under this Section will be a full and complete discharge of any liability of such a Participant under the Plan.

Section 5.13 Indemnification. To the extent permitted by law, the Company will indemnify any current or former employee or director of the Company against any and all liability or claim of liability (to the extent not indemnified under any liability insurance contract or other indemnification agreement) which the person incurs on account of any act or failure to act in connection with the good faith administration of the Plan, including all expenses incurred in the person's defense if the Company fails to provide a defense after having been requested to do so in writing. The right to indemnification under this Section is conditioned upon the person notifying the Company of any claim of liability within 30 days of the person's notice of that claim and granting the Company the right to participate in and control the settlement and defense of that claim.

Section 5.14 Misrepresentation or Fraud. A person who receives a benefit under an arrangement or policy as a result of providing false, misleading or fraudulent information shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including reasonable attorney fees. Coverage received under an arrangement or policy that is subject to the PPACA shall only be rescinded retroactively if false, misleading or fraudulent information was provided intentionally by the Participant, his spouse or dependent, subject to the Participant's right to notice and appeal as required under the PPACA and regulations promulgated thereunder.

Section 5.15 HIPAA Compliance. The Plan will comply with the "privacy regulations" and the "security regulations" found at 45 CFR Parts 160 and 164, as they may be amended from time to time, issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the Omnibus Final Rule (as issued on January 23, 2013), governing the use and disclosure of protected health information ("PHI") and electronic protected health information ("ePHI") (as those terms are defined under HIPAA and its regulations) to the extent they apply to the Plan. Consequently, the Plan, through the Administrator, will establish and maintain a privacy and security plan that will describe the policies, practices and procedures that will be maintained and followed by the Plan to comply with the requirements of HIPAA and its regulations. The privacy and security plan will include a description of the permitted and required uses and disclosures by the Plan of any PHI created or obtained by the Plan, including disclosures to the Company and will require the Company to reasonably and appropriately safeguard ePHI created, received, maintained or transmitted to or by the Company on behalf of the Plan. The privacy and security plan will be maintained for so long as it is required by the HIPAA regulations. The privacy and security plan will:

(a) Describe the rules and procedures for maintaining adequate separation between the Plan and the Company with respect to any PHI in the Plan's possession. This will include:

(1) A description of the individuals under the Company's control who will be given access to PHI, including those who may receive the PHI in the Plan's ordinary course of business.

(2) Rules and procedures for restricting access to and use of PHI as required by HIPAA and the privacy regulations.

(3) An effective mechanism for resolving any issues of noncompliance by any individuals described in paragraph (1) above.

(b) Describe specific rules for limiting disclosures of PHI to the Company. The rules will require, before the Plan will disclose any PHI to the Company, that the Company provides a certificate that the Plan has been amended to incorporate items (1) through (10) below and the Company to agree:

(1) Not to use or further disclose PHI other than as permitted or required by the Plan and the privacy plan or as required by applicable law;

(2) To ensure that any agents or subcontractors to whom it provides PHI that it receives from the Plan will similarly abide by the same restrictions that apply to it;

(3) Not to use or disclose any PHI for employment related actions or decisions, or in connection with any other benefit or employee benefit plan;

(4) To report to the Plan any use or disclosure of information that is inconsistent with the permitted uses or disclosures of which the Company becomes aware;

(5) To make PHI available only to the extent consistent with the Plan's privacy plan;

(6) To make PHI available to the extent required to fulfill the requirements related to Plan's policy regarding the right to request an account of disclosures;

(7) To make its internal practices, books, and records relating to the use or disclosure of PHI that it receives from the Plan available to the Secretary of the Department of Health and Human Services for audit purposes;

(8) If feasible, to return or destroy all PHI received from the Plan that the Company retains, in any form, when no longer needed for the purpose for which the disclosure was made;

(9) To ensure that adequate separation between the Plan and the Company exists to assure the confidentiality of all PHI; and

(10) To adopt a risk assessment and breach notification procedure in the event that the Plan becomes aware of a breach of unsecured PHI for which notification could be required under the HITECH Act.

(c) Designate the Plan's "privacy officer" and "security officer."

(d) The security provisions of the plan will require the Company to:

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

(2) Ensure that adequate separation between the Company and the Plan is supported by reasonable and appropriate security measures;

(3) Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI; and

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

Section 5.16 PPACA Compliance. The medical arrangement shall comply with all mandates applicable to that arrangement under the PPACA (as amended and modified by the Health Care and Education Affordability and Reconciliation Act), and all regulations promulgated thereunder by the Departments of Health and Human Services, Labor and Treasury. Any disclosures required by PPACA and its implementing regulations to be made to Participants shall be included in the summary Plan description distributed to Participants.

ARTICLE VI

Funding

The Company will pay all costs of providing the benefits available under the Plan. The Company will pay the cost for any self-funded benefits from its own general assets and from withholdings or payments from employees as determined by the Administrator from time to time. The premiums and other charges for the policies provided under this Plan will also be paid by the Company and, to the extent determined by the Administrator, by withholdings or payments from employees. The Administrator may set different Participant contribution rates and charges from time to time in its sole and absolute discretion for each arrangement and policy and for different Participants or groups of Participants.

ARTICLE VII

Amendment and Termination

Any part or all of the Plan (including an arrangement or policy) may be amended by the Company at any time in its sole discretion. While the Company expects and intends to continue the Plan, it also reserves the right to terminate the Plan, in whole or in part, at any time in its sole discretion. In the event of the dissolution, merger, consolidation or reorganization of the Company, the Plan will terminate unless the Plan is continued by resolution of the board of directors of a successor to the Company.

ARTICLE VIII

Participation By Affiliates

Section 8.1 Affiliate Participation. Any Affiliate may adopt the Plan and become an Employer under the Plan by:

(a) filing a certified copy of a resolution of its Board of Directors, Board of Managers or similar governing body to that effect with the Company; and

(b) obtaining the Company's consent to that action.

Section 8.2 Company Action Binding on Other Employers. As long as the Company is an Employer under the Plan, it is empowered to act for any other Employer in all matters relating to the Plan.

FOREST RIVER, INC.
WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

SUMMARY PLAN DESCRIPTION
FOR THE
FOREST RIVER, INC.
WELFARE BENEFIT PLAN

INTRODUCTION

This document is a summary of the FOREST RIVER, INC. WELFARE BENEFIT PLAN (referred to as the "Plan"). The Plan is designed to provide self-funded benefits and insurance protection for the eligible employees of Forest River, Inc. (the "Company"). The purpose of this document is to acquaint you with the general provisions of the Plan and to advise you of your rights as a participant under the Plan. It is intended to be an easily understood explanation of the more important Plan provisions. However, the Plan itself is a detailed legal document, written in accordance with federal law. Should this summary differ in any way from the provisions of the Plan, the terms of the Plan will govern. All benefits under the Plan are provided pursuant to either self-funded arrangements or insurance contracts between the Company and the insurance companies. The rights and benefits of each self-funded arrangement and insurance policy are set forth in the insurance certificates, benefit schedules, summaries or booklets you received. Those certificates, schedules, summaries or booklets and this summary should be kept as part of your records. We encourage you to carefully review this summary and the insurance certificates, schedules, summaries or booklets and to ask the Plan Administrator any questions you have concerning the Plan. Copies of the Plan, insurance contracts and benefit schedules, summaries or booklets are on file at the Company's principal office and may be reviewed by any Plan participant, or any other person entitled to benefits under the Plan, upon request. To obtain a copy of the Plan document, please contact the Plan Administrator.

This summary reflects the provisions of the Plan effective as of January 1, 2020.

TABLE OF CONTENTS

Page

GENERAL INFORMATION

Plan Name
FOREST RIVER, INC. WELFARE BENEFIT PLAN

Plan Number (PN)
510

Name, Address, Telephone Number and Employer Identification Number (EIN) of the Plan Sponsor
Forest River, Inc.
P.O. Box 3030
900 County Road 1
Elhart, IN 46515-3030
(574) 389-4600
EIN: 20-3284366

Plan Type
The Plan described in this summary plan description is a "welfare benefit plan" providing self-funded and fully-insured benefits to eligible individuals as set forth in Appendix A to the Plan.

Plan Year
The Plan's records are kept on the basis of a "Plan-Year", which begins each January 1 and ends on the next following December 31.

Plan Administrator
The Company serves as the Plan Administrator. The Company, as the Plan "sponsor" and "named fiduciary," may designate a committee or a third party to serve as the Plan Administrator or to perform some or all of the Plan Administrator function.

Name, Address and Telephone Number of Plan Administrator
Forest River, Inc.
P.O. Box 3030
900 County Road 1
Elhart, IN 46515-3030
(574) 389-4600

Type of Administration and Source of Funding
The Plan provides self-funded and fully-insured benefits. Benefits are provided through self-funded benefit arrangements or through insurance policies issued by the insurance companies listed in Appendix A to the Plan. Claims for benefits must be sent to the applicable claims administrator or insurance company. The claims administrators and insurance companies are responsible (not the Company) for paying claims under the Plan. The Plan Administrator, claims administrators and insurance companies share responsibility for administering the Plan. Plan expenses and insurance premiums are paid in part by the Company and, if applicable, through contributions made by employees through the Section 125 plan maintained by the Company.

Service of Legal Process
Legal process may be served upon the Company or upon the person designated by the Company as its resident agent in the Office of the Secretary of State for the State of Indiana.

ELIGIBILITY AND PARTICIPATION

As an employee of the Company, you will become a Participant in the Plan when you become eligible for coverage under an arrangement or an insurance policy offered through the Plan in accordance with the terms and conditions specified in the arrangement or policy. You will be covered under the arrangement or policy at the time, for the period and under the conditions specified in that arrangement or policy. A copy of all the benefit schedules, summaries, insurance certificates or booklets describing the policies and arrangements, rules and benefits has been provided to you. Please review the eligibility information contained in the applicable insurance certificates, benefit schedules, summaries or booklets, and contact the Company if you have any questions.

Eligibility Criteria. You are eligible to participate in the medical and pharmacy arrangement if you are an active employee of the Company. You are eligible to participate in the dental, vision, basic life, accidental death and dismemberment, voluntary life, short-term disability and voluntary worksite benefits policies and employee assistance program if you are an active full-time employee of the Company. You are eligible to participate in the long-term disability policy if you are an active salaried employee of the Company.

You are eligible to begin coverage under the medical and pharmacy arrangements and the dental, vision, basic life, accidental death and dismemberment, voluntary life, short-term disability and voluntary worksite benefits policies and employee assistance program on the first day of the month following 60 days of employment. You are eligible to begin coverage under the long-term disability on the first day of the month following initial year of salaried employment. Your dependents are eligible if they meet the definition of dependent as described in the applicable self-funded arrangements and insurance policies.

Please review the additional eligibility information contained in the benefit schedules, summaries, insurance certificates or booklets you have received, and contact the Company if you have any questions.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are an otherwise eligible employee and you decline to participate in the medical, pharmacy, dental or vision coverage provided under the Plan when first eligible or at open enrollment, you and/or your dependents may have the right to elect such coverage upon occurrence of a "special enrollment event" as provided by HIPAA. HIPAA special enrollment events generally occur when you or your dependents lose coverage under another employer's group health plan (unless due to failure to pay premiums), and when you gain a dependent through marriage, birth or adoption. You have 30 days from the occurrence of one of these events to notify the Company and enroll in the applicable arrangement or policy. You and/or your dependents may also have special enrollment rights if coverage is lost under Medicaid or a State Children's Health Insurance Program ("SCHIP"), or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the Company and enroll in the applicable arrangement or policy.

CONTRIBUTIONS AND FUNDING

The Company will provide for the Plan's funding through its general assets and the maintenance of insurance policies. The expenses for the self-funded arrangements and the premiums for the policies will be paid by the Company, and to the extent determined by the Company, by you. To the extent that you are eligible and elect to do so, you may pay your share of the cost of contributions and premiums on a pre-tax basis through your participation in the Company's Section 125 plan. The Company will determine and periodically communicate your share of the cost of the contributions and premiums. The Company may change the amount of the contributions and premiums you are required to pay at any time in its sole discretion.

SUMMARY OF PLAN BENEFITS

The Plan provides you and, for some benefits, your eligible dependents with welfare benefits as set forth in Appendix A to the Plan. As mentioned above, these benefits are provided under self-funded arrangements or group insurance contracts and are described in the benefit schedules, summaries, insurance certificates or booklets you have received and in Appendix A to the Plan.

The address and phone number of each claims administrator or insurance company is listed in the applicable insurance certificate, benefit schedule, summary or booklet.

All benefits under the Plan are provided in accordance with the terms and conditions of the self-funded arrangements and insurance policies.

GENERAL RULES

Qualified Medical Child Support Order

With respect to medical, pharmacy, dental and vision coverage (the "medical coverages"), the Plan will provide benefits as required by any qualified medical child support order ("QMCSO"). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

Benefits for Adopted Children

With respect to the medical, pharmacy, dental and vision coverage, the Plan will provide benefits to dependent children placed with you or your beneficiary for adoption under the same terms and conditions as apply in the case of dependent children who are the natural children of you or your beneficiary. Please see the eligibility provisions described in the applicable insurance certificates or booklet for details regarding adding an adopted child to your coverage.

Special Rights on Childbirth

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

HIPAA Compliance

The Plan must comply with certain requirements under the Standards for *Privacy of Individually Identifiable Health Information* (the "Privacy Regulations") and the *Security Standards for the Protection of Electronic Protected Health Information*, (the "Security Regulations"), 45 CFR 160 and 164, as updated by the HITECH Act and regulations promulgated thereunder. The Plan will receive and handle PHI in accordance with its privacy and security procedures set forth in the Plan Document. In addition, the Plan may receive and disclose to the Plan sponsor information on whether the individual is participating in a policy or is enrolled in or has disenrolled from the medical, pharmacy, dental and vision coverage offered by the Plan. The Plan will also safeguard electronic protected information in accordance with the Security Regulations, including implementing or addressing, as reasonable in light of the limited electronic protected information received by the Plan, the administrative, technical and physical safeguards found in the Security Regulations. You have certain other rights that must be provided to you by the administrators and insurers offering the medical, pharmacy, dental and vision coverage under the Plan. Please contact each insurer, claims administrator or the Plan Administrator directly regarding your HIPAA Privacy and Security rights.

AMENDMENT OR TERMINATION OF THE PLAN

The Company, as the Plan sponsor, has the right to amend the Plan at any time, in any fashion, in its sole discretion. While the Company expects and intends to continue the Plan, it also has the right to terminate the Plan at any time in its sole discretion.

CLAIMS PROCEDURES

Each insurance company or claims administrator is responsible for evaluating all benefit claims under the insurance policy or benefit arrangement it issued under the Plan. The applicable insurance company or claims administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and the Patient Protection and Affordable Care Act (the "PPACA"), if applicable. The insurance companies and claims administrators have the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

You should review the appropriate insurance certificate, benefit schedule, summary or booklet for more information about how to file a claim and for details regarding the claims administrator or insurance company's claims procedures.

If your claim is denied, you may appeal to the insurance company named or claims administrator for a review of the denied claim. The insurance company or claims administrator will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and the PPACA, if applicable. If you don't appeal on time, you may lose your right to file suit in a state or federal court, as you may have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

You should review the appropriate insurance certificate, benefit schedule, summary or booklet for more information about how to appeal a denied claim and for details regarding the claims administrators' or insurance companies' claims procedures.

Information for disability claims

The disability benefits provided under this Plan are subject to Department of Labor regulations governing the adjudication and review of disability claims set forth in 29 CFR § 2560.503. These adjudication and review procedures are set forth in the applicable policy, certificate, arrangement or supplement. To the extent the third-party claims administrator's arrangement or insurer's policy is inconsistent or incomplete, the Plan will comply with those regulations.

You have specific rights under the disability claims regulations. These are fully set forth in the applicable policy, certificate, or supplement. The following is a summary of those rights. If the Plan denies your claim in whole or in part, written notification of the claims decision (called an "adverse benefit determination") will be provided in writing or electronically. It will include all of the following that pertain to the determination: 1) the specific reason(s) for denial; 2) the specific plan provision(s) on which denial is based; 3) a description of any additional information needed to further decide the claim and an explanation of why the information is needed (if applicable); 4) a description of the Plan's review procedures and the time limits applicable to such procedures, and 5) a discussion of the decision, including an explanation of the basis for disagreeing with the views of your medical or vocational professionals, medical or vocational professionals hired by the Plan, or a disability determination by the Social Security Administration. If a claim is denied on appeal, you will receive a final written decision stating why the appealed claim is denied, reference any specific plan provision(s) on which denial is based, and the calendar date by which you have a right to file suit. Any specific internal rules, protocols, standards or other similar criteria relied upon in making the adverse benefit determination will be provided or made available to you. You may request, free of charge, copies of documents, records, and other information relevant to your claim. In addition, the term "adverse benefit determination" includes not only a claim denial, but any rescission of disability coverage. A rescission in this context includes any retroactive cancellation or discontinuation of coverage, unless the cancellation or discontinuation is due to failure to timely pay premiums.

NO ENLARGEMENT OF EMPLOYMENT RIGHTS

Nothing contained in the Plan, the self-funded arrangements, insurance policies or this summary is to be construed as a contract of employment between the Company and you, nor can the Plan be deemed to give you the right to be retained in the employ of the Company, or limit the right of the Company to employ or discharge any person or to discipline any employee.

SUBROGATION

If you or your covered dependents have medical expenses attributable to injuries suffered in an accident and the accident was caused by the negligence or misconduct of another person, the Plan has the right to seek payment of those medical expenses from that person. The Plan may also recover any amount it paid to you to the extent you receive payment for the expenses from another party.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

COBRA continuation coverage is a continuation of Plan coverage when coverage (including the medical and pharmacy arrangements and the dental and vision policies) would otherwise end due to a "qualifying event." Specific qualifying events are listed below. Upon the occurrence of a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent-children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage with after-tax dollars.

Who is entitled to elect COBRA Continuation Coverage?

If you are an employee, you will become a qualified beneficiary if you will 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 will 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; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will 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; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Special qualifying event for Retirees

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

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. You and/or your dependents will be provided a notice of your right to elect COBRA continuation coverage within forty-four days after the Company's Plan Administrator receives your notice of a qualifying event. If, after the Plan Administrator receives your notice of a qualifying event, he or she determines that you and/or your dependents are not eligible for COBRA continuation coverage, the Plan Administrator will provide an explanation containing the reasons you or your dependents are not eligible for coverage. The Plan Administrator will also notify you or your dependents if you are enrolled in COBRA continuation coverage if your COBRA continuation coverage terminates prior to the end of the maximum applicable coverage period.

Sometimes, the Company Must Notify the Plan Administrator:

The Company will notify the Plan Administrator of you or your dependent's qualifying event when the qualifying event is the end of employment or reduction of hours of employment, or death of the employee. You need not notify the Company of any of these three qualifying events.

Sometimes, You Must Notify the Plan Administrator:

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent-child's losing eligibility for coverage as a dependent-child), you must notify the Plan Administrator. The Plan requires you to provide written notification of the qualifying event to the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the address provided below. IF YOU DO NOT NOTIFY THE PLAN ADMINISTRATOR OF THE QUALIFYING EVENT WITHIN 60 DAYS AFTER THE QUALIFYING EVENT OCCURS, YOU WILL NOT BE ABLE TO ELECT TO RECEIVE COBRA CONTINUATION COVERAGE.

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. You may elect COBRA continuation coverage on behalf of your spouse, and you or your spouse may elect COBRA continuation coverage on behalf of your children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the initial 18-month period of COBRA continuation coverage. You should send such notice of disability to the address provided below.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can obtain additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the address provided below.

Please send Notices, in writing, to the COBRA Administrator designated below:

Loomis
P.O. Box 7011
850 North Park Road
Wyomissing, PA 19610-6011

If you have questions about your COBRA continuation coverage, you can write: Forest River, Inc., Attn: Plan Administrator, P.O. Box 3030, 900 County Road 1, Elkhart, IN 46515-3030 or call the Human Resources Department at (574) 389-4600. You may also contact the COBRA Administrator listed above. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes:

In order 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.

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the Company's medical arrangement for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if required to be filed, and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report, if a Form 5500 Series is required to be filed.

COBRA and HIPAA Rights

If you are covered under the Plan's medical or pharmacy arrangements or dental or vision policies, you may be eligible to continue coverage for yourself, spouse or dependents if there is a loss of coverage under that arrangement or policy as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description, the applicable plan arrangements, certificates or booklets, and other documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining your Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or 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 concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. Employee Benefits Security Administration addresses and telephone numbers are available through the EBSA website at www.dol.gov/ebsa.

APPENDIX A

PLAN ARRANGEMENTS AND POLICIES

Effective as of January 1, 2020

Section A-1 Benefits Provided Through Self-Funded Arrangements: Self-funded benefits are provided through the following arrangements and administered by a third-party claims administrator:

(a) Medical benefits administered by UMR, Inc., a third-party claims administrator.

(b) Pharmacy benefits administered by Express Scripts, Inc., a third-party claims administrator.

Section A-2 Benefits Provided Through Insurance Policies: Insured benefits are provided under group insurance policies and certificates issued to the Company by the following insurance companies:

(a) Health Resources, Inc.: group dental insurance.

(b) Vision Service Plan: group vision insurance.

(c) Unum Life Insurance Company of America: basic life, accidental death and dismemberment, voluntary life, short-term disability and long-term disability insurance and employee assistance program.

(d) Reliastar Life Insurance Company dba Voya: voluntary accident benefits insurance.

(e) Madison National Life Insurance Company, Inc.: voluntary worksite benefits insurance.