Employee Benefit Plan Summary of Material Modifications

Benefits Summary: What's New for 2024

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

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

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

Summary of Changes:

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

1. On April 10, 2023, the President signed a resolution formally terminating the COVID-19 National Emergency period, ending certain COVID-related benefit requirements.

   Section 1. Introduction. **The following section was deleted:**

   Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines
   In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the National Emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 5121 et seq. or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

   1) The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);
   2) The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
   3) The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
   4) The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
   5) The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
   6) The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
   7) The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
   8) The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

   This period may also be disregarded in determining the applicable date for the Plan's duty to provide a COBRA election notice under ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue to follow all established COBRA parameters.

   In no instance will the duration of an extension granted under this section exceed one calendar year.

   The disregarded period (one calendar year) for an individual to elect COBRA continuation coverage and the disregarded period (one calendar year) for the individual to make initial and subsequent COBRA premium payments will generally run concurrently.

   Section 5. Schedule of Benefits. **The following section was deleted:**

   COVID-19 (2019 Novel Coronavirus) Testing (covered at 100% both Network and Non-Network Providers)
   The Plan will:
   • Cover the costs of OTC COVID-19 tests for participants either directly (referred to in the as "direct coverage") or by requiring participants to pay for the tests upfront and then submit a claim for reimbursement. starting Jan. 15 without the need for a health care provider's order.
   • Make tests available for upfront coverage through preferred pharmacies or retailers and provides direct coverage of OTC COVID-19 tests both through its pharmacy network and a direct-to-consumer shipping

program, it may limit reimbursement for OTC COVID-19 tests from nonpreferred pharmacies or other retailers to the lesser of $12 per test or the actual cost of the test.
• Set limits on the number of OTC COVID-19 tests covered without cost-sharing but must allow up to eight tests per plan enrollee per 30 days (or calendar month). A family of four, all on the same plan, would be able to get up to 32 of these tests covered by their health plan per 30- day period (or calendar month).
•May take reasonable steps—such as requiring a written attestation—to ensure that each OTC COVID-19 test for which you seek coverage under the Plan was purchased for personal use, not for employment purposes; has not been (and will not be) reimbursed by another source; and is not for resale.
• Require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC COVID-19 test.
• May not set limits on the number of covered tests if these are ordered by a health care provider following a clinical assessment.

Section 6. Additional Coverage Details. **The following section was deleted:**

(y) **COVID-19 (2019 Novel Coronavirus).** Covered Expenses associated with testing for COVID-19 include the following:

• *Diagnostic Tests.* The following items are covered at 100%, deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Pre-Authorization. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan. If the cash price is not posted, reimbursement will be made in accordance with the current Plan terms.

- In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
  - that are approved, cleared, or authorized by the FDA;
  - for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
  - that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
  - that are deemed appropriate by the Secretary of Health and Human Services.
- Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

• *Qualifying Coronavirus Preventive Services.* The following items are covered at 100%, deductible waived, and do not require Pre-Authorization.

- An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
- An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

• *Telehealth and Other Communication-Based Technology Services*. Covered Persons can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Covered Person believes he or she has COVID-19 symptoms.
• *Requests for Prescription Refills*. When considering whether to cover a greater-than-30-day-supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.

The above benefits are specific to diagnosis COVID-19. Covered Persons who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

Section 8. Utilization Management Program. **The following paragraph was deleted:**

Note: During the Outbreak Period of COVID-19, this Plan waives the pre-authorization requirement for oxygen and supplies.

2. Section 5. Schedule of Benefit. **The following benefit was updated as follows:**

The Plan covers the following tobacco cessation products at no cost up to six (6) months in a Calendar Year when prescribed by a Network Provider and purchased at a Network Pharmacy:

- Bupropion SR 150 mg (generic/prescription
- Varenicline Tabs (generic/prescription)
- Nicotine Replacement Therapy (NTR) limited to:
  - Nicotine Patches (generic/over-the-counter)
  - Lozenges (generic/over-the-counter)
  - Gum (generic/over-the-counter)
  - Inhaler (generic/prescription)
  - Nasal Spray (generic/prescription)

3. Section 13. Claim Review and Audit Program**. The following definition was amended as follows:**

2. Guidelines. The following guidelines will be used when determining Allowable Claim Limits:

a. Facilities. The Allowable Claim Limit for claims by a facility, including but not limited to, hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care facility, shall be the greater of (I) 112% of the facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. The Allowable Claim Limit for (I) shall not exceed 250% of the federal non-commercial Medicare allowed amount, except for children's hospitals, which shall not exceed 350% of the federal non-commercial Medicare allowed amount. If insufficient information is available to identify either the facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

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

1. Section 4. Schedule of Benefits.

Effective January 1, 2024, Orthodontic Treatment is a covered dental service with a Lifetime Maximum of $2,000 per covered member and 50% Coinsurance.

2. Section 5. Defined Terms. **The following definition was amended as follows:**

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

3. Section 6. Plan Exclusion. **The following exclusion was deleted:**

Orthodontic Treatment. Orthodontic Treatment unless such insurance is provided under the list of covered dental services.