Summary Plan Description

IOGA WV INSURANCE PROGRAM

For Health, Dental, Vision, Short Term Disability, and Life Insurance

Available to Members of the

INDEPENDENT OIL AND GAS ASSOCIATION OF WEST VIRGINIA, INC.

Effective for Plan Year 2019

Summary Plan Description Date: November 1, 2018

The following information, together with the information contained in the Component Benefit Plans listed in Appendix A constitute the Summary Plan Description.

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Overview

This summary plan description together with the Component Benefit Plans listed in Appendix A summarize the Health, Dental, and Vision insurance contracts provided by insurance companies to Members of the Independent Oil and Gas Association of West Virginia, Inc. ("IOGA") when the policies are purchased by or through an employer, for example an oil and gas producing company. IOGA is an incorporated trade association. Membership in IOGA is only available to employers in the oil and gas industry in West Virginia. IOGA is not an insurance provider and assumes no obligation of insurance under the Plan. IOGA does not provide any of the insurance payments or services under the insurance policies referred to in this Plan.

The Benefits of the Plan are the rights acquired when insurance is purchased and all other obligations under the insurance policies are met. You must determine from your employer whether insurance is available. This Plan merely permits the purchase of insurance by in good standing IOGA Members accepted by insurers. Insurance benefits are only available when insurance is purchased. The insurance policies purchased state and define what is covered by those policies. You should read the insurance contracts and disclosure documents carefully, share them with your family, and keep them for future reference. Insurance terminates when the premiums are not paid or an employer is no longer an IOGA member in good standing. Additionally, you must comply with the terms of the applicable insurance policy.

Plan Information

Name of Plan	IOGA WV INSURANCE PROGRAM 300 Summers Street, Suite 820 Charleston, WV 25301
Employer	You do not have an employment relationship with IOGA by virtue of anything within this Summary Plan Description. IOGA is an association of employers.
IOGA's EIN	IOGA's EIN is 310894437. If you need your employer's Employer Identification Number, please obtain it from your employer.
Plan Number	501
Plan Year End Date	Plan Year ends every December 31st

Plan Sponsor	Independent Oil and Gas Association of West Virginia, Inc. 300 Summers Street, Suite 820 Charleston, WV 25301
Plan Administrator	Insurance Committee Independent Oil and Gas Association of West Virginia, Inc. 300 Summers Street, Suite 820 Charleston, WV 25301 (304) 344-9867
Named Fiduciary	Insurance Committee Independent Oil and Gas Association of West Virginia, Inc. 300 Summers Street, Suite 820 Charleston, WV 25301
Agent for Service of Legal Process	IOGA's Agent for service of Legal Process is: Charles Burd 300 Summers Street, Suite 820 Charleston, West Virginia 25301 Service of legal process may also be made on the Plan Administrator:
Trustee	Tom Hansen, Chairman Insurance Committee of the Independent Oil and Gas Association of West Virginia, Inc. 8 Capitol Street, Suite 500 Charleston, West Virginia 25301
Insurers:	Medical – Highmark West Virginia, Inc. Dental – United Concordia Vision – Vision Service Plan Insurance Company Life – Dearborn National Life Insurance Company Short Term Disability –Dearborn National Life Insurance Company United Concordia is an affiliate of Highmark of West Virginia, Inc.

Type of Welfare Plan

The following benefits may be available for purchase pursuant to this Plan: Medical, Dental, Vision, Life and Short-Term Disability insurance. The insurance is offered by the insurance

providers listed above or in Appendix A. Employers select insurance from the list in Appendix A.

Funding Mechanism/ Type of Administration

Fully Insured

If a Benefit is described as fully insured, it is administered in accordance with the terms and conditions of an insurance contract or contracts for the benefit of the Insurer(s). Upon payment of premiums and compliance with the policies, the insurance company is responsible for paying claims with respect to the insured Benefits. This is a Fully Insured plan. Your employer is responsible to deliver the full amount billed for insurance premiums to the IOGA Insurance Trust. The Insurance Trust reserves two percent (2.0%) of amounts paid by the employer to the Trust for administration and costs related to the Plan, and pays over the balance of the amount received by the Trust to the insurance companies that issue the policies. The IOGA Insurance Trust may pay a portion of the insurance premium on one or more types of insurance from its funds, but has no obligation to do so. If the IOGA Insurance Trust pays any portion of any premium, it will do so without discrimination. The portion of the premium paid by an employer is separately determined by each employer. Eligibility for insurance benefits may require an employee to pay certain premiums, deductible amounts and/or copayments as determined by the insurance purchased and offered by the employer. You should consult the Summary of Benefits and Coverage for the insurance made available by your employer. You should consult with your employer regarding the amount paid by your employer and the amount you pay.

Funding under this Plan.

Each employer elects the insurance products under this Plan that will be made available to its employees and sets the portion of the premiums due that will be paid by the employer and the employee. The employer submits the payments to the Sponsor, which deposits the payments into the Independent Oil and Gas Association of West Virginia Insurance Fund Trust (the "Trust") bank account at BB&T, Charleston, West Virginia. The Trustees of the Trust in turn pay the premiums on the insurance policies after receipt from the employer.

Eligibility

If you are designated as a full-time employee (defined as reasonably expected to average 30 or more hours of service per week), your eligibility to participate in the Plan will commence on the first day of the following month after their date of hire or the first day of the following month after you have met your probationary period. The probationary period cannot exceed 2 months. Under some insurance contracts, an employer has the option to permit full time employment if you are reasonably expected by your employer to average at least 20 or more hours per week.

A summary of the eligibility requirements for each Benefit is described in the documents referred to in Appendix A and incorporated herein.

If your employer and the Plan Administrator classify your position as one of the following, your eligibility for benefits under the Plan will be determined according to the Affordable Care Act and its related regulations:

- a part-time employee not reasonably expected to average 30 or more hours of service per week;
- a variable hour employee not reasonably expected to average 30 or more hours of service per week; or
- a seasonal employee hired to work in a position relating to a particular season or period generally lasting 6 months or less.

The following employees are not eligible to participate in the Plan:

- Collectively bargained employees, to the extent such employees are covered by a collective bargaining agreement that specifies benefits are provided by another entity or organization, unless such agreement specifies collectively bargained employees will be covered under the Plan; and
- Nonresident aliens with no US-sourced income, as defined under Code Section 861(a)(3).

Eligibility for your "Dependents" (meaning your spouse and/or dependent child as determined under the applicable Benefit) is also found under the terms of the applicable Benefit in Appendix A.

Termination of Coverage

You will cease being a Participant in the Plan and coverage under the insurance purchased under this Plan for you and your Dependents will terminate in accordance with the termination provisions of the Benefit documents set forth in Appendix A or as stated in this Summary Plan Description. You may become ineligible for any Benefit if you fail to pay the applicable premiums or meet other requirements of an applicable Benefit. You may also become ineligible for benefits to the extent you are designated by your employer, the Plan Administrator or the insurance companies who issue insurance policies referred to in this plan as being a variable hour or seasonal employee and you have not met the hours of service requirement under the applicable measurement period, as described in Appendix B. Your employer must remain an IOGA member in good standing for the insurance available under the plan to continue.

Contribution Requirements

The source of funding for each Benefit varies with each employer who elects to purchase insurance available through the Plan. Please consult with your employer. Participant contributions may be required for some or all Benefits. If Participant contributions are required, you may be permitted to make pre-tax salary elections through your employer-provided cafeteria plan to pay for certain benefits. For more information refer to the cafeteria plan document or contact your employer.

Benefits

Details of the benefits provided under the Plan are described in the Benefit Documents that are referred to in Appendix A and incorporated herein.

Special Rights on Childbirth

Health insurance issuers offering group health insurance coverage 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 normal vaginal delivery, or less than 96 hours following a caesarian section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans 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 the above periods.

Special Rights on Relating to Mastectomy

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 the insurance purchased, as described in the applicable Benefit Document. Please check the applicable Benefit Document for

information on the application of deductibles and coinsurance. If you would like more information on WHCRA benefits, you may contact the Plan Administrator at 304 344 9867.

Mid-year Benefit Changes

Generally, the benefits that you elect at open enrollment remain in effect through the entire Plan Year. However, you may be able to make certain mid-year changes to your post-tax benefits, as identified in Appendix A.

In addition, you may be able to make certain mid-year changes to your pre-tax benefits, as identified in Appendix A, provided the change meets standards set forth by the Internal Revenue Service. These changes, described below, are called status changes, and you must notify your employer and the Plan Administrator within 30 days of experiencing a status change event (or within 30 days or 60 days, as applicable, for a HIPAA special enrollment event, as described below).

Status Changes

You may be able to make changes to your Medical, Dental, Vision, Short Term Disability or Life insurance if you experience a mid-year status change and can provide sufficient documentation of the event to the satisfaction of the insurers from whom insurance is purchased, your employer, the insurer who issues the insurance and the Plan Administrator. The following events are considered status changes:

- Change in legal marital status (such as marriage, divorce, death of spouse, legal separation and annulment);
- Change in number of dependents (such as birth, adoption, placement for adoption and death. *See also, HIPAA Special Enrollment, below.*);
- Change in employment status (such as termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, or a change in worksite that affects benefits eligibility);
- Beginning or returning from FMLA leave;
- Dependent satisfies or ceases to satisfy dependent eligibility requirements (such as due to age);
- Residence change (if the change affects benefits eligibility); and
- Commencement or termination of adoption proceedings.

Any status change must also satisfy Internal Revenue Service "consistency" rules, which generally require the status change to be on an account of and correspond with an event that affects benefits eligibility. This also means that the change you make to your coverage has to be consistent with the status change. Please contact the insurance providers for more information.

Other Changes

You should consult with your employer. It is possible that if any of the following events take place mid-year, you may also be able to make a mid-year change to certain pre-tax benefits:

- Cost changes (such as significant increase or decrease of coverage costs);
- Significant coverage changes (such as significant restrictions or detrimental coverage changes, significant addition or significant improvement of a coverage option);
- Changes under another employer's plan (such as different open enrollment periods);
- Reduction of hours of a full-time employee to below 30 hours of service per week on average combined with enrollment or intent to enroll in Marketplace or other coverage;
- Enrollment in Marketplace coverage during Marketplace annual open enrollment or mid-year special enrollment; or
- Loss of other group health plan coverage (such as loss of governmental or educational institution's coverage, state children's health insurance program (CHIP), or foreign government group health plan);

HIPAA Special Enrollments

If you experience one of the following HIPAA special enrollment events and give proper notice within the timeframes indicated below, you may make medical plan elections mid-year, which would include enrolling a Dependent or Spouse:

- Acquisition of a new dependent (such as marriage, birth, adoption and placement for adoption, if notice is provided to the Plan Administrator within 30 days of the event);
- Loss of coverage under a group health plan (such as under a spouse's plan, including termination of employer contributions); or

- Gain or loss of eligibility under Medicaid or state children's health insurance program (CHIP) (if notice is provided no later than 60 days after the date of the event)

To ensure proper notice, you should timely notify (i) your employer, (ii) the insurers who issue the insurance purchased in connection with this plan, and (iii) the Plan Administrator within the timeframes indicated below, you may make medical plan elections mid-year.

All HIPAA special enrollment events must meet the requirements under HIPAA regulations.

Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) is a final court or administrative agency order that generally results from a divorce or legal separation and that provides for health benefit coverage for a child of a participant under a group health plan. Federal law requires the Plan to provide medical benefits to any eligible Dependent of a Participant pursuant to a QMCSO.

Participants and beneficiaries may obtain, without charge, a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator. If a QMCSO requires the Plan to provide coverage to your eligible child, your eligible child can be added to the plan mid-year, or as otherwise required by the QMCSO.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to USERRA. You may contact the Plan Administrator and the insurer who issues the policy for more information.

COBRA Continuation Coverage

If you or your Dependent's coverage under the Plan ends, you and your Dependent(s) may be able to continue your medical, dental, and vision insurance benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Cobra coverage is offered through Life Time Benefits Solutions.

COBRA coverage is a continuation of the insurance available for purchase pursuant to this Plan when coverage would otherwise end due to a life event known as a qualifying event. After a qualifying event, each qualified beneficiary has the opportunity to acquire Cobra coverage. You, your spouse, and dependent children could become qualified beneficiaries if

you lose coverage due to a qualifying event. Qualified beneficiaries who elect COBRA coverage must pay for such coverage.

This is intended to provide you with a general explanation of your rights and obligations under the continuation coverage provisions of COBRA that arise in case of certain qualifying events such as termination of employment (except for gross misconduct), reduction in hours, death, divorce or legal separation, or a child ceasing to be a dependent. If you are married, both you and your spouse should take the time to read this information carefully.

If you elect COBRA coverage, you receive the same medical, dental, vision insurance benefits available through your employer and under this Plan to active participants. Qualified beneficiaries who elect COBRA coverage must pay for the coverage.

Qualifying Events

If you are a Participant covered by a medical Benefit, you are entitled to COBRA coverage if you lose your group health coverage as a result of:

- A reduction in the number of hours that you work for the Employer; or
- Termination of your employment.

If you are the enrolled Dependent Spouse of a Participant covered by a medical Benefit, you are entitled to choose continuation of coverage for yourself if you lose your group health coverage for any of the following reasons:

- Death of your spouse;
- A reduction in your spouse's hours of employment, or termination of your spouse's employment; or
- Divorce or legal separation from your spouse.

An enrolled Dependent Child of a Participant covered by a medical Benefit is entitled to continuation coverage if he or she loses coverage for any of the following reasons:

- Death of the employee;
- A reduction in the employee's hours of employment, or termination of the employee's employment;
- The employee's legal separation or divorce;
- The dependent ceases to qualify as a "dependent child" under the medical Benefit.

A child who is born to or placed for adoption with a Participant during the COBRA continuation coverage period is a qualified beneficiary and is an eligible dependent for the remainder of the employee's or spouse's period of continuation coverage. You must notify the Plan Administrator within 30 days of the birth or placement for adoption.

Who Can Elect COBRA Continuation Coverage?

Each qualified beneficiary has an independent right to elect COBRA coverage. Covered employees may elect COBRA coverage on behalf of their spouses. Parents may elect coverage on behalf of their children, and an employee or his or her spouse may elect coverage on behalf of all qualified beneficiaries.

Notice Requirements

You or your spouse or dependent must notify the Plan Administrator within 60 days of the following qualifying events:

- Divorce or legal separation from your spouse; and
- Your child's loss of dependent eligibility under the Plan.

To extend COBRA coverage in the event of a second qualifying event, you must notify the Plan Administrator within 60 days of the occurrence of the second qualifying event. You must also inform the Plan Administrator within 60 days of the date a person is determined to be disabled according to the terms of the Social Security Act of 1965, as amended.

Your notice to the Plan Administrator must be in writing and include the following information: (a) the name of the employee; (b) the name(s) of the qualified beneficiary(ies) who will lose coverage under the Plan due to the event; (c) the type of qualifying event; and (d) the date on which the event occurred.

Electing COBRA Coverage

Upon receipt of notice as described above, the Plan Administrator will notify you and/or your dependent(s) of the right to elect COBRA continuation coverage ("Election Notice"). Each qualified beneficiary has an independent right to elect COBRA coverage. Covered employees may elect COBRA coverage on behalf of their spouses; parents may elect coverage on behalf of their children; and an employee or his or her spouse may elect coverage on behalf of all qualified beneficiaries.

You and/or your dependents have 60 days from the date of the Election Notice (or the date coverage would be lost due to one of the qualifying events described above, if later) to elect continuation coverage. Elections must be made in writing on the form provided by the Plan Administrator. Election Forms must be returned to the Plan Administrator and post-marked within the 60-day election period.

For more information regarding your rights under ERISA and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA web site at www.dol.gov/ebsa.

Duration of Continuation Coverage

For each qualified beneficiary who timely elects and pays for COBRA continuation coverage, coverage begins on the date that coverage under the plan otherwise would have been lost due to the qualifying event. The maximum period for which COBRA coverage can be continued depends upon the type of qualifying event and when it occurs.

If the qualifying event is your death; enrollment in Medicare; divorce or legal separation; or your child's loss of dependent eligibility, COBRA coverage extends up to 36 months from the date on which coverage is lost due to the qualifying event.

If the qualifying event is: a reduction in your hours of employment; termination of your employment (except for gross misconduct); or your failure to return from FMLA leave, COBRA coverage generally lasts up to 18 months from the date on which coverage is lost.

Subsequent Events

Once a newborn or adopted child is enrolled in continuation coverage, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for the child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).

If you, your spouse or dependent experience one of the qualifying events listed below while receiving 18 months of COBRA coverage, your spouse and dependents may be entitled to 18 more months of coverage, up to a total of 36 months, but only if the event would have caused your spouse and dependent to lose coverage under the Plan had the first qualifying event not occurred.

- Your death;
- Your enrollment in Medicare;
- Divorce or legal separation from your spouse; or
- Your child's loss of dependent eligibility under insurance purchased by you and/or your employer.

To extend COBRA coverage in the event of a second qualifying event, you must notify the Plan Administrator within 60 days of the second qualifying event. Such notice must be in writing and include the following information: (a) the name of the employee; (b) the second qualifying event; (c) the date on which the event occurred; and (d) the names of the covered individuals whose coverage will be lost as a result of the event. You also must include a copy of:

- The employee's death certificate, divorce decree or proof of legal separation; or
- The child's birth certificate or other proof of age as applicable depending on the qualifying event.

Special Rules for Medicare

If you first become entitled to Medicare during the COBRA continuation period, you no longer will be eligible to continue coverage under COBRA. However, the coverage period for any qualified beneficiaries in your family receiving 18 months of continuation coverage will be extended an additional 18 months up to 36 months from your termination of employment or reduction in your hours.

If you become covered by Medicare fewer than 18 months before your termination of employment or reduction in your hours, continuation coverage is available for your covered dependents for up to 36 months from the date of Medicare enrollment or 18 months from your termination of employment, whichever period is longer.

Special Rules for Disability

If you or a covered Dependent are totally disabled (as determined by the Social Security Administration ("SSA") at the time of your termination of employment or reduction in your hours, or become disabled (as determined by SSA) during the first 60 days of an 18-month period of COBRA continuation coverage, continuation coverage is available for all eligible family members for up to 29 months instead of up to 18 months.

The monthly rates for the additional 11 months, however, will be 48 percent higher than those for the initial 18-month period. To qualify for this additional period of coverage, you or the covered dependent must notify the Plan Administrator in writing within 60 days of the latest of: (i) the date of the SSA determination; (ii) the date of your initial qualifying event; (iii) the date on which you lost coverage due to the initial qualifying event; or (iv) the date on which you are informed of these procedures for providing this notice and within the initial 18-month period of continuation coverage.

Your written notice must include: (i) the covered employee's name; (ii) the qualified beneficiary's (ies') name(s); (iii) the name of the person who has been determined to be disabled by SSA; and (iv) the date of the determination. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. The Social Security disability determination must reflect an approval date prior to or within the first 60 days of your 18-month COBRA period or reduction in hours. In the case of a child born to or placed for adoption with a covered employee during the period of COBRA continuation coverage, the 60 days is measured from the date of birth or placement for adoption. The period of extended COBRA continuation coverage ceases for all family members on the first day of the first month that begins more than 30 days after the disabled person no longer qualifies for Social Security disability benefits (unless the initial 18-month COBRA period has not yet expired). You are required to notify the Plan Administrator in writing within 30 days of any such final determination.

Cost of COBRA Coverage

You do not have to show that you are healthy to choose to continue coverage. However, you will have to pay the premium for your continuation coverage. You generally will be required to pay 102% of the total cost of the coverage being continued (except in cases of extended continuation coverage due to disability, in which case you will be required to pay 150% of the cost of coverage).

You're the Plan Administrator, your former employer, or the insurers who offer insurance available through this Plan will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and will also notify you of any changes in the monthly COBRA premium amount. Payment amounts for each coverage option are listed in the Election Notice. Payments must be made by check or money order, payable to the insurance company which will issue at the following address:

Lifetime Benefit Solutions, Inc.
115 Continuum Drive
Liverpool, NY 13088
800-828.0078

Although payments are due on the first of each month, you have a grace period after the due date to remit payment. COBRA coverage will be provided as long as each payment is made before the end of the grace period for that payment. If you fail to make a payment before the end of the grace period, you lose all rights to COBRA coverage under the Plan.

Termination of COBRA Coverage

COBRA coverage will terminate before the end of the maximum coverage period if:

- A required premium is not paid in full and on time;
- After electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not enforce a pre-existing condition exclusion against the person;
- A qualified beneficiary enrolls in Medicare after electing COBRA coverage;
- A covered employee who lost coverage due to termination of employment, a reduction in hours, or failure to return to work after FMLA leave becomes eligible to participate in the Plan;
- SSA determines that a qualified beneficiary with extended COBRA coverage due to a disability is no longer disabled;
- The Plan is terminated; or
- A qualified beneficiary commits an act that would result in termination of coverage for a participant or beneficiary not receiving COBRA coverage (e.g., filing fraudulent claims).
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Claims Procedures

Fully Insured Benefits

The insurer that provides insured Benefits is responsible for paying claims and making benefits decisions for the Benefits under the plan. The claims procedures applicable to the Benefits are described in the applicable Benefit document in Appendix A.

No Plan Self-Insured Benefits

If a Benefit is described as self-funded or self-insured by the Employer, claims are paid from the Employer's general assets in accordance with the terms of the Plan and claims administration is done by the Employer or a third party administrator (which may be an insurer acting in an administrative capacity). There are no self insurance benefits in connection with this Plan. Insured Benefits may be provided subject to deductibles, coinsurance, and employee contributions as described in the applicable Benefit Document. Please check the applicable Benefit Document for information on the application of deductibles and coinsurance. Consult with your employer regarding the amount of the premiums you pay.

Special Rules for Group Health Plan Claims

Under ERISA, there are three categories of claims under a group health plan and each one has a specific timetable for approval, payment, request for additional information, or denial of the claim. The three categories of claims are:

1. Urgent Care Claim is a claim where failing to make a determination quickly could seriously jeopardize your life, health, or ability to regain maximum function, or could subject you to severe pain that could not be managed without the requested treatment. With respect to medical claims only, an attending provider with knowledge of your medical condition may determine if a claim is an Urgent Care claim.

2. Pre-Service Claim is a claim for which you are required to get advance approval or pre-certification before obtaining service or treatment for the medical services.

3. Post-Service Claim is a request for payment for covered services you have already received.

Time for Decision on a Claim

The time deadline for making decisions on claims depends on the urgency of the claim. You will be notified of any determination on the claim (whether favorable or unfavorable) as soon as possible. If an Urgent Care Claim is denied, you will be notified orally and written

notice will be provided within three days. The deadlines shown on the chart below are maximum time limits.

Time Limit	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
To make initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Plan's control	No Extension Permitted	15 days (one time only)	15 days (one time only)
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days
For claimant to request extension of course of treatment	24 hours before expiration of previously approved course of treatment	15 days before expiration of previously approved course of treatment	Not applicable
For claimant to request appeal	180 days	180 days	180 days
To make determination on appeal	72 hours	15 days for First-Level Appeal; 15 days for Second-Level Appeal	30 days for First-Level Appeal; 30 days for Second-Level Appeal

Notification of Denial

Except for Urgent Care Claims, when notification may be oral followed by written notice within 3 days, you will receive written notice if the claim is denied, known as an adverse benefit determination. With respect to medical coverage benefits only, rescissions of coverage (retroactive terminations), to the extent permitted under applicable law, will be considered adverse benefit determinations. Adverse benefit determinations will result in a notice containing the following information:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the determination was made;
3. A description of any additional material or information necessary to perfect the

claim and an explanation of why such material or information is necessary;

4. A description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of your right to bring a civil action under ERISA section 502 if the claim is denied on review;
5. 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;
6. If an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided free of charge upon request;
7. If the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request;
8. date of service;
9. the health care provider;
10. if applicable, the claim amount;
11. the denial code;
12. a statement that diagnosis and treatment codes and their meanings will be provided upon request;
13. description of the Plan's standard used in denying the claim;
14. a description of the external review processes; and
15. the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Claim Denial

If your claim is denied, you (or your attorney or other person authorized to act on your behalf) will have 180 days following the date you receive written notice of the denial in which to appeal the claim. Please review the applicable insurance contracts carefully. A failure to timely file an appeal request will constitute a waiver of your right to request a review of the denial of the claim. Unless you are appealing the denial of an Urgent Care Claim, the request for review should be made in writing. If you are requesting review of an Urgent Care Claim, you may request review orally or by facsimile. A request for review should contain your name and address, the date you received notice the claim was denied, and the reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to the claim. Upon request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The period of time for the Plan and insurer to review the appeal request depends on the type of claim, as set forth in the preceding chart. The review will take into account all comments, documents, records, and other information submitted relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. If your claim is denied, a Plan fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination will review your claim. The Plan fiduciary will provide an independent full and fair review of your claim and shall not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

With respect to medical claim benefits only, such benefit will continue pending the resolution of internal appeals. In addition, with respect to urgent medical benefits claims only, to the extent such claims require an ongoing course of treatment, you may expedite the external review process before the Plan's internal review process is completed. Medical coverage will continue pending the outcome of the internal appeal.

Denial of an appeal will result in a notice containing substantially the same information outlined above.

Special Rule for Medical Benefit Claims

With respect to medical benefit claims only:

1. Claims are reviewed, processed, and accepted or denied by the insurers in accordance with the insurance policies selected by the Employer. The Plan Administrator will ensure that all claims and internal appeals are handled impartially by ensuring the independence and impartiality of the persons involved in making the decision. Any decisions by your employer regarding hiring, compensation, termination promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Plan Administrator shall ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

2. Prior to deciding an appeal, the Plan Administrator, or the insurer, will provide you with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim.

3. With respect to internal claims, you will be able to review your file and present information as part of the review. Before making a benefit determination on review, the Plan Administrator or the insurer will provide you with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision.

4. Subject to regulatory limitations, if the Plan fails to adhere to all the requirements of the internal claims and appeals process with respect to the claim, you will be deemed to have exhausted the internal claims and appeals process and may request an

expedited external review before the Plan's internal appeals process has been completed. However, this will not apply if the error was *de minimus*, if the error does not cause harm against you, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In the event of *de minimus* errors, you may resubmit the claim for internal review.

Right to External Review

To the extent required by law, the Plan will comply with external review rules under the Patient Protection and Affordable Care Act and its supporting regulations, to the extent such rules apply to adverse medical benefit determinations. You may request external review of adverse medical benefit determinations but only for claims involving medical judgment or a rescission, as determined by the external reviewer. No external review is available for adverse medical benefit determinations not related to medical judgment or rescissions. Valid external review claims must be requested within four months of the date of an adverse medical benefit determination. Eligible claims will be reviewed by an independent review organization and the claimant will be provided with a determination. Such determinations are generally binding on the Plan and the claimant, except if federal law allows additional recourse.

Disability Claims

Only a limited short-term disability policy is available under this Plan. A disability claim is a claim that requires determination of whether you are disabled for purposes of eligibility for benefits under one or more Component Benefit Plans. A disability claim determination must be made within 45 days. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator. Contact the Plan Administrator and insurer which issued the insurance for procedures for submitting a disability claim.

Amendment and/or Termination of the Plan

The Plan Administrator reserves right, in its sole discretion, to amend, amend and restate, or merge the Plan at any time and from time to time, including the right to amend any of the Benefits, including amendments that are retroactive in effect to the extent permitted by applicable law, without the consent of any person. Any amendment may include the addition, modification, or deletion of a Benefit.

The Plan Sponsor reserves the right, in its discretion, to suspend, discontinue, or terminate the Plan, in whole or in part, at any time and from time to time, including termination of any one or more of the Component Benefit Plans, without the consent of any person. In the event

an insurer terminates an insurance contract for any Benefit, such termination will also be considered a termination under these terms.

To the extent that plan assets exist upon termination of the Plan, they shall be used only for the exclusive benefit of plan participants and beneficiaries.

Overpayments

If, for any reason, any benefit is erroneously paid or exceeds the amount payable under the Plan to you or your Dependents or Spouse, you will be responsible for refunding the overpayment to the Plan to the fullest extent permitted by law.

In addition, if the Plan or any insurer who issues insurance referred to in this Summary Plan Description makes any payment that, according to the terms of the Plan or the applicable insurance policy, as the case maybe, should not have been made, any insurance company listed in Appendix A, the Plan Administrator, or the Plan Sponsor (or designee) may, to the fullest extent permitted by law, recover that incorrect payment, whether or not it was made due to the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party.

Solely at the discretion of the Plan Administrator or insurance company who issues the policy, the refund or repayment may be made in one or a combination of the following methods: (a) as a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from your pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurance company. The Plan or insurers may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Right of Subrogation and Reimbursement

This Plan does not provide or pay benefits, instead, benefits are provided by the insurers under each policy. However, if the Plan pays benefits to or for any Participant, Dependent, or Spouse for any injury, illness, expense, or loss, the Plan will be subrogated for the full amount of such payments to all rights of the Participant, Dependent, or Spouse, or any assignee of either of them against any person, firm, corporation or other entity in connection with any claim related to the injury, illness, expense, or loss. The insurance policies available under the Plan may also include subrogation rights. Please review those policies carefully.

This Plan does not provide or pay benefits, instead, benefits are provided by the insurers under each policy. However, if the Plan pays benefits to or for any Participant, Dependent, or Spouse for any injury, illness, expense or loss caused, or alleged to be caused, by any person, and the Participant, Dependent (or someone acting on behalf of the Dependent), Spouse, or any assignee of any of them obtains any recovery from any source in connection

with the injury, illness, expense or loss, whether by lawsuit, settlement or otherwise, including any recovery from the Participant's insurance, and regardless of how the recovery is characterized or named, the Plan shall be entitled to full reimbursement from the Participant, Dependent (or person acting on behalf of the Dependent), Spouse, or any assignee of any of them to the full extent of the Plan's payments.

The Plan's rights of subrogation and reimbursement under the above provisions shall have first priority and shall not be reduced for any reason, including for attorney's fees, the "fund" doctrine, the "common fund" doctrine, comparative or contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other defenses or doctrines that may affect the Plan's right to subrogation or reimbursement. Likewise, the Plan's right to subrogation or reimbursement shall exist and be enforceable without regard to whether the Participant, Dependent (or person acting on behalf of the Dependent), or Spouse is "made whole" for his, her, or their loss. Notwithstanding the above, the Plan Administrator or the Plan Administrator's designee may determine, in the exercise of its sole discretion, to reduce the Plan's recovery in appropriate circumstances, which may include, with respect to attorney's fees, a condition that the attorney representing the Participant, Dependent, Spouse, or assignee, has agreed in advance to honor the rights of the Plan with respect to subrogation and reimbursement contained herein.

Once a covered person has any reason to believe that he/she may be entitled to recovery from any source, the covered person must notify the Plan. Prior to payment by the Plan to or for a Participant, Dependent (or someone acting on behalf of the Dependent), or Spouse for any injury, illness, expense, or loss caused, or alleged to have been caused, in circumstances that may support a recovery from any person, the Participant, Dependent (or other adult acting on behalf of a minor Dependent), and Spouse will be asked to execute a subrogation and reimbursement agreement consistent with the terms of this section. Failure to request or obtain such an agreement prior to the payment by the Plan shall not in any way diminish the Plan's rights of subrogation and reimbursement herein. If a covered person fails or refuses to execute the required subrogation or reimbursement agreement, the Plan may deny payment of any benefits to the covered person until the agreement is signed. Alternatively, if a covered person fails or refuses to execute the required subrogation or reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the covered person, the covered person's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement, and the covered person's agreement to a constructive trust, lien and/or equitable lien by agreement in favor of the Plan on any payment, amount or recovery that the covered person recovers from any source. Please refer to the applicable insurance policy for provisions regarding subrogation and reimbursement.

By participating in the Plan, each covered person consents and agrees that, once Plan benefits are paid, a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any payment, settlement, or recovery relating to an injury, illness, expense, or loss for which the Plan has provided benefits. In accordance with that

constructive trust, lien, or equitable lien by agreement, each covered person agrees to cooperate with the Plan by reimbursing it for Plan benefits received.

The Participant, Dependents, and Spouse shall do nothing to prejudice the Plan's rights under this section and shall promptly inform the Plan of the name and address of any attorney representing the Participant, Dependent, Spouse, or assignee. The Participant, Dependents, and Spouse shall assist the Plan upon request, including instituting legal proceedings against any appropriate persons, firms, corporations, or entities.

In the event that the Plan is not fully reimbursed as set out in this section, the Plan shall have the right, as the Plan Administrator or the Plan Administrator's designee may determine, in the exercise of its sole discretion, to reduce any future benefits to which the Participant, Dependent, Spouse, or assignee is or may become entitled, by the amount not reimbursed or recovered by the Plan.

Non-alienation of Benefits

Except as otherwise provided in an applicable Benefit, in a QMCSO, or pursuant to a voluntary assignment of benefits to a health care provider or facility providing health care services covered by the Plan, no benefit, right, or interest of any Participant, Dependent, or Spouse covered under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or be subject to, the debts, liabilities, or other obligations of such person, except as otherwise required by law; any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute, or levy upon, or otherwise dispose of any right to benefits payable hereunder, shall be void.

Fraud or Misrepresentation

If you receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. False or misrepresented information could cause you and your dependent's coverage to terminate irrevocably and retroactively to the extent permitted by law, and could be grounds for employee discipline up to an including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. The Plan Administrator may ask you for proof of eligibility for a dependent, and any other information or proof as required by the Plan. If you fail to comply with a request by the Plan for information or proof within a reasonable period of time, the Plan may delay payment of any benefits that may be due under the Plan until such information or proof is received. The Plan may rely on any information furnished by you, and this information will be conclusively binding upon you.

Disclaimer

Benefits are provided pursuant to the Benefits and selected by your employer and premiums are paid. If the terms of this document conflict with the terms of any insured Benefit, then the terms of the insured Benefit will control.

No Contract of Employment

The Plan does not create a contract of employment or any obligation of continued service of any employee.

No Retirement Benefits.

No retirement benefits are offered in connection with the Plan. This Plan does not provide any pension benefits.

Statement of ERISA Rights

Your 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 the following.

You can examine, without charge, at the human resources office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements (if applicable), 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 Employee Benefits Security Administration.

You can 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.

The plan administrator is required by law to furnish each participant with a copy of the summary of his/her annual financial report.

Continue Group Health Plan Coverage

You can 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 regarding 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 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 under the Plan 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 it 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 that 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 if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, or to request documents, you should contact Lori Miller Smith, at 304 344 9867. 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 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.

Maintaining a current address

It is important and will help you to keep the Plan Administrator, your employer, and any insurance company which is obligated to provide you benefits of your current address, and the current addresses of all beneficiaries of insurance. You should also keep a copy, for your records, of any notices you send to the Plan Administrator, the insurance company,

Appendix A – Component Benefit Plans – that is, insurance available

	Medical	**Dental**	**Vision**
Plan name	SuperBlue Plus 2000	Concordia Flex Plan	VSP Choice Plan
Plan #			
Insurer	Highmark BlueCross BlueShield	United Concordia	Vision Service Plan Insurance Company
Policy #			
Address	614 Market Street, Parkersburg WV 26101	4401 Deer Path Road, Harrisburg, PA 17110	3333 Quality Drive Rancho Cordova, CA 95670
Phone #	304-424-7776	800-332-0366	800-851-5000
Funding Mechanism	Fully Insured	Fully Insured	Fully Insured
Source of Contributions	Employer or Employee payments Contributions Vary by Employer	Employer or Employee payments Contributions Vary by Employer	Employer or Employee payments Contributions Vary by Employer
Eligibility Guidelines	Eligibility Varies by Employer	Eligibility Varies by Employer	Eligibility Varies by Employer
Termination Criteria	Criteria Varies by Employer	Criteria Varies by Employer	Criteria Varies by Employer
	Potential Medical Policies – the Employer selects the policy or policies that are available to employees – Deductible Amounts are for in network service		
	$1,000 Deductible – 90/70 Plan		
	$2,000 Deductible – 90/70 Plan		
	$3,000 Deductible – 90/70 Plan		
	$3,500 Deductible – 90/70 Plan		
	$4,000 Deductible – 90/70 Plan		
	$1,000 Deductible – 90/70 Plan – 25/35/50		
	$2,000 Deductible – 90/70 Plan – 25/35/50		
	$3,000 Deductible – 90/70 Plan – 25/35/50		
	$3,500 Deductible – 90/70 Plan – 25/35/50		
	$4,000 Deductible – 90/70 Plan – 25/35/50		
	$5,000 Deductible – 90/70 Plan – 25/35/50		
	$6,000 Deductible – 90/70 Plan – 25/35/50		
	2017 HDHP Non Emb 100% ($1500/Deductible)		

	2017 HDHP Emb 100% ($2,700/Deductible)	`	
	2017 HDHP Emb 100% ($4,000/Deductible)		
	2017 HDHP Mixed Emb 100% ($5,000/Deductible)		

All employees who enroll in health, dental or vision insurance may obtain additional information regarding the insurers below through the following websites:

Health (Highmark): highmarkbcbswv.com

Vision (VSP): vsp.com

Dental: (United Concordia) – ucci.com