Gangloff Industries, Inc.
Health and Welfare Benefit Plan Document and Summary Plan Description
First Amendment and Summary of Material Modification (SMM)

This First Amendment to the Gangloff Industries, Inc. Health and Welfare Benefit Plan Document and Summary Plan Description ("Plan") is made on the date noted below, by Gangloff Industries, Inc. ("Employer").

WHEREAS, the Plan grants the Employer the right to amend the provisions of the Plan, and

WHEREAS, the Employer desires to make such amendments;

NOW, THEREFORE, the Plan is hereby amended as follows, with such amendment to be effective as of June 1, 2016:

The attached Schedule of Benefits effective June 1, 2016 replaces the Schedule of Benefits that was effective June 1, 2015.

The following shall be replaced in the **DEFINITIONS** section:

HOSPITAL

Means a place which:

- Is legally operated for the inpatient care and treatment of ill or injured persons;
- Is mainly engaged in providing medical and diagnostic services;
- Has continuous 24 hour nursing services; and
- Has a staff of one or more physicians available at all times except when the facility meets the definition of Residential Treatment Facility in this Plan.

IN-NETWORK FAMILY DEDUCTIBLE

The maximum amount of deductible a covered family must pay in a Calendar Year for services provided by Preferred Providers. This amount is shown on the Schedule of Benefits. The In-Network Family Deductible may be satisfied by combining all amounts applied to In-Network Individual Deductibles for the covered employee and the covered employee's dependents for the Calendar Year. No one Participant will be required to satisfy more than the applicable Individual In-Network Deductible. However, only covered expense that is incurred in a Calendar Year and applied to that same Calendar Year's In-Network Individual Deductible can be used to satisfy the In-Network Family Deductible.

OUT OF NETWORK FAMILY DEDUCTIBLE

The amount of deductible a covered family must pay in a Calendar Year for services provided by Non-Preferred Providers. This amount is shown on the Schedule of Benefits. The Out of Network Family Deductible may be satisfied by combining all amounts applied to Out of Network Individual Deductibles for the covered employee and the covered employee's dependents for the Calendar Year. No one Participant will be required to satisfy more than the applicable Individual Out-of-Network Deductible. However, only covered expense that is incurred in a Calendar Year and applied to that same Calendar Year's Out of Network Individual Deductible can be used to satisfy the Out of Network Family Deductible.

OUT OF POCKET MAXIMUM – In-Network

Any share of a covered expense the Participant is required to pay for In-Network covered expenses. This Maximum includes any In-Network Deductible, In-Network Coinsurance and Copay amounts applied to covered services. No one Participant will be required to satisfy more than the applicable Individual Out of Pocket Maximum. Non-covered services and benefit reductions are not included in this Maximum.

OUT OF POCKET MAXIMUM – Out-of-Network

Any share of a covered expense the Participant is required to pay for Out-of-Network covered expenses. This Maximum includes any Out-Of-Network Deductible and Out-of-Network Coinsurance amounts applied to covered services. No one Participant will be required to satisfy more than the applicable Individual Out of Pocket Maximum. Copays/Access Fee, non-covered services and benefit reductions are not included in this Maximum.

The following shall be added in the **DEFINITIONS** section:

RESIDENTIAL TREATMENT CENTER

A facility, licensed as such under applicable law, whose primary function is offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with mental health conditions, serious mental health conditions and/or Substance Use Disorders.

It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

The following bullets will be deleted and replaced with the in the **AMOUNT OF BENEFIT FOR COVERED HEALTH EXPENSES** section:

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Delete:

- For expense incurred for outpatient speech therapy by a licensed or certified speech therapist to restore speech loss or correct impairment due to a congenital defect for which corrective surgery has been performed, or an injury or illness except for a mental, nervous or emotional disorder will be considered covered expense when preapproved, as shown on the Schedule of Benefits and as required by the Plan. The visit limit will not apply when pre-approval of the treatment has been obtained and is for the treatment of:
    - burns;
    - fractures;
    - joint replacements;
    - immediately following surgery; or

- immediately following a stroke

And replaced with:

- For expense incurred for outpatient speech therapy by a licensed or certified speech therapist to restore speech loss or correct impairment due to a congenital defect for which corrective surgery has been performed, or an injury or illness will be considered covered expense when preapproved, as shown on the Schedule of Benefits and as required by the Plan. The visit limit will not apply when pre-approval of the treatment has been obtained and is for the treatment of:
  - burns;
  - fractures;
  - joint replacements;
  - immediately following surgery; or
  - immediately following a stroke

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Delete:

- For treatment of autism spectrum disorders/pervasive developmental disorder that is prescribed by the Participant's treating physician in accordance with a treatment plan. All deductibles and maximum dollar limits apply to this treatment. Other exclusions or limitations do not apply to this treatment.

And replace with:

- For treatment of autism spectrum disorders/pervasive developmental disorder that is prescribed by the Participant's treating physician in accordance with a treatment plan.

Gangloff Industries, Inc.

By: Randy Ferguson

Its: CEO

Schedule of Benefits
Effective 6/1/2016
Gangloff Industries, Inc.

Expenses must be eligible under the plan, medically necessary and the most cost-effective medically appropriate care.

	Plan Type - PPO	In Network	Out of Network
Deductible per Calendar Year	Single	$5,000	$10,000
	Family - Cumulative	$10,000	$20,000
	Deductibles must be met before benefits are paid.		
	Deductible amounts accumulate separately for In and Out of Network benefits.		
	Where co insurance is listed it is assumed that deductible is paid first.		
	All individual deductible amounts will satisfy the family deductible, but no one participant will be required to pay more than the individual deductible amount.		
Out of pocket: maximum per Calendar year	Single	$6,450	$20,000
	Family - Cumulative	$12,900	$40,000
	Out of pocket maximum includes: annual medical deductible and prescription drug benefits.		
	Out of Pocket amounts accumulate separately for In and Out of Network benefits.		
	All individual deductible amounts will satisfy the family deductible, but no one participant will be required to pay more than the individual deductible amount.		
Lifetime Maximum Benefits		unlimited	unlimited

Precertification Requirements

Your plan requires that certain services be precertified. It is your responsibility to call Medical Cost Management (MCM) 888-641-5304 to pre-certify your service or confirm that your service has been precertified, on your behalf, by your medical provider.
Failure to obtain precertification for your services will result in monetary penalties or exclusion of coverage.
Services Requiring Precertification include but may not be limited to:
72 hours advanced precertification for all scheduled inpatient admissions, overnight observation stays.
Urgent/Emergency Inpatient admissions require precertification within 2 business days.
following the admission/service.
Please refer to your Health Plan for further details.

Case Management

Your plan requires that certain services have Case Management Prior Authorization.
It is your responsibility to call the Case Manager at 888-301-0747, extension 3155
Case Management can provide assistance with the following services:
Durable medical equipment, injectable medications (i.e. Lovenox, Enbrel, Humira, Avonex, Byetta, etc.),self injectable medications (except insulin), home health care, orthotics, prosthetics, chemotherapy, radiation therapy, transplants, skilled nursing and hospice, insulin pump, diabetic or ostomy supply, most medical supplies, artificial eyes, limbs or larynx, bariatric surgery and clinical trials.
If you or a family member are faced with a complex or long-term health concern such as cancer, diabetes, amputation, organ transplant, kidney failure/dialysis, or any other serious health issue, our Case Management Services can help you with many of your needs.
Refer to your Health Plan for full listing or contact us for assistance.

Network

This is a PPO Plan which contains a Network Provider Organization based on your location. ***Please refer to ID card for correct network identification.***

Sagamore Plus Health Network	800-320-0015 or go online to www.sagamorehn.com
PHCS	888-955-7427 or www.groupplansolutions.com ("Member" and "Find A Provider")

On Line Tools

View your claim information securely on line, anywhere, anytime, with Group Plan Solutions at **www.groupplansolutions.com**

To find a Provider
Go to Member> Select Find a Provider
Click the Find a Provider button
Please reference your ID card to determine your correct network.

To view Claim Information
Go to Member> Select Claim Inquiry.
Click the Health Claim/Webeci button.
Log in with your user name and password

Still need help? Call us at 888-301-0747
Be sure to check out the other great tools and resources available at **www.groupplansolutions.com**

Contact Numbers

Group Plan Solutions	888-301-0747	FAX 309-478-2912
Prescription Coverage	888-301-0747	EXT: 2976
Additional ID Cards	888-301-0747	2976
Case Management Prior Authorization	888-301-0747	EXT: 3155
Precertification: MCM	888-641-5304	
PPO Network Questions:	888-301-0747	2975

Schedule of Benefits
Effective 6/1/2016
Gangloff Industries, Inc.

Expenses must be eligible under the plan, medically necessary and the most cost-effective medically appropriate care.
Where co insurance is listed it is assumed that deductible is paid first

Category	Description	In Network	Out of Network
Preventative Care		You Pay	You Pay
	Routine Preventive Care office visits	$0	Not covered
	Preventive lab and x-ray	$0	Not covered
	Pap smear and mammogram	$0	Not covered
	Prostate screening	$0	Not covered
	Routine Immunizations	$0	Not covered
Physician Services			
	Office visits- evaluation and management services	20% co insurance	50% co insurance
	Digagnostic procedures and diagnostic therapeutics	20% co insurance	50% co insurance
	High Tech Diagnostic Service (i.e. MRI, MRA, CT and PET)	20% co insurance	50% co insurance
	Diagnostic lab and x-ray	20% co insurance	50% co insurance
Facility Services			
	Inpatient Hospital Stay - **Precertification required**	20% co insurance	50% co insurance
	High Tech Diagnostic Services (i.e. MRI/MRA, CAT Scan, PET Scan)	20% co insurance	50% co insurance
	Diagnostic lab and x-ray	20% co insurance	50% co insurance
	Outpatient - Diagnostic and Surgery	20% co insurance	50% co insurance
	Ambulatory Surgical Facility	20% co insurance	50% co insurance
	Emergency Room Services/ includes physicians professional fee -Access fee waived if admitted)	$75 Access Fee for Emergency Services/in network deductible and 20% co insurance.	
	Emergency Room Services/Non Emergent	Not covered	Not covered
Other Medical Services			
	Urgent Care Facility - evaluation and management services	20% co insurance	50% co insurance
	Emergency Medical Transportation	20% co insurance	50% co insurance
	Maternity Services	20% co insurance	50% co insurance
	Maternity Services - Routine Prenatal	0% co insurance/deductible waived	50% co insurance
	Therapy - Outpatient Occupational, Speech, Physical - **20** visits per calendar year, each therapy type.	20% co insurance	50% co insurance
	Inpatient Rehabilitation Services - **Precertification required.**	20% co insurance	50% co insurance
	Chiropractic Treatment/Spinal Manipulation - limited to **20** visits per calendar year	20% co insurance	50% co insurance
	Durable Medical Equipment - **Case Management Prior Authorization required**	20% co insurance	50% co insurance
	Prosthetic - must be medically necessary - **Case Management Prior Authorization required**.	20% co insurance	50% co insurance
	Hospice Care - **Case Management Prior Authorization is required**	20% co insurance	50% co insurance
	Home Health Care - Limited to **90** visits per calendar year -**Case Management Prior Authorization is required.**	20% co insurance	50% co insurance
	Skilled Nursing Facility - Short term non custodial care **90** days per calendar year. **Case Management Prior Authorization required.**	20% co insurance	50% co insurance
	Organ Transplants - **Case Management Prior Authorization is required**.	Office Visit and Hospital Care Coinsurance apply. Center of Excellence requirement as stated in the Covered Health Expenses	
	Bariatric Surgery - when requirements are meet. **Case Management Prior Authorization is required**	20% co insurance	50% co insurance
	Cardiac Rehabilitation Services - **36** treatments per 6 month period.	20% co insurance	50% co insurance
	Infertility Services	Not covered	Not covered
	TMJ	Not covered	Not covered
	Injectable Medication, including Self Injectable Drugs except insulin - **Case Management Prior Authorization is required.**	20% co insurance	50% co insurance
Mental Health, Chemical and Alcohol Dependency			
	Inpatient Hospital stay - **Precertification is required.**	20% co insurance	50% co insurance
	Outpatient & office therapy	20% co insurance	50% co insurance
Pharmacy		Generic/Preferred Brand/Non- Preferred	
	Retail - 30 days supply	20% co insurance	Not covered
	Retail - 90 days supply	20% co insurance	Not covered
	Mail order - up to 90 day supply	20% co insurance	Not covered

Insulin is the only injectable processed under the drug card. All other Injectable medications will be processed under the medical coverage and require **Case Management Prior Authorization**
Self Injectable Medications - covered under the medical coverage, see Other Medical Services and require Prior Authorization.

Prescription Benefit Program

Your prescription benefit program is managed through Magellan Rx

View Formulary and to Locate a Pharmacy	www.magellanrx.com
Customer Service	800-424-5828
Mail Order	800-424-5828