AmFirst Insurance Company

201 Robert S. Kerr Ave, Suite 600
Oklahoma City, Oklahoma 73102

Administrative Offices:
P.O. Box 14067, Jackson, MS 39236

For Inquiries, Information or Complaints, Please Call (888) 538-6941.

POLICYHOLDER:	Multiplex Display Fixture Company dba The Miller Group	POLICY NUMBER:	27109
		EFFECTIVE DATE:	April 1, 2023
ADDRESS:	1610 Design Way Dupo, IL 62239	DATE OF ISSUE:	April 1, 2023

This Policy of Insurance summarizes your rights and benefits under the Policy. Coverage is provided under the Policy for benefits described in the Policy. Benefits payable are subject to all of the provisions contained in the Policy. READ THESE PAGES WITH CARE.

All periods of time under the Policy will begin and end at 12:01 A.M. local time at the Policyholder's address.

The insurance of the Insured reflected by this Policy is further subject to any modifications of the Policy entered into by mutual agreement between the Company and the Policyholder as of the date of such modification.

President

Right of Examination

If for any reason You are not satisfied with this Policy, You may return it to Us within ten (10) days after You receive it. Any premium paid will be refunded.

THIS POLICY CONTAINS A DEDUCTIBLE PROVISION.

GROUP MEDICAL SUPPLEMENT POLICY

THIS IS A LIMITED HEALTH INSURANCE PLAN NOT BEING OFFERED AS A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE OR MAJOR MEDICAL EXPENSE INSURANCE

RENEWABLE AT THE OPTION OF THE COMPANY

NON-PARTICIPATING

PLEASE READ CAREFULLY

This policy is not a Medicare supplement policy. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

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POLICY SCHEDULE OF STANDARD BENEFITS

Benefit Year: ..... Calendar

Major Medical Deductible Covered ..... Yes

Major Medical Coinsurance Covered ..... Yes

Major Medical Facility Copayment Covered ..... Yes

Maximum Total Benefit Amount $5,000

Deductible (Family Cap X2) $3,000

Coinsurance (Individual/Family) ..... N/A

Copayment Amount ..... No

Maximum Out-of-Pocket $3,000

Outpatient Physician's Expense Benefit ..... No
Copayment Amount (per visit) ..... N/A
Maximum Number of Visits (per person, per year) ..... N/A

THIS SCHEDULE IS ATTACHED TO AND MADE PART OF THIS POLICY. THIS SCHEDULE REPLACES AND CANCELS ALL OTHER SCHEDULES ISSUED PRIOR TO THE EFFECTIVE DATE FOR THE ELIGIBLE PERSONS UNDER THIS CERTIFICATE.

DEFINITIONS

Whenever used in this Policy:

Accident means a sudden and unexpected event resulting in Injury.

Benefit Year means the one (1) year period of time specified in the Schedule for which all benefits are determined. It may be either a Calendar Year or a Policy Year.

Calendar Year means the one (1) year period beginning January 1 and ending December 31 of the same year.

Certificate means the Certificate of Insurance issued to the Insured. It describes the coverage under this Policy.

Company, Our, We or Us means AmFirst Insurance Company.

Coinsurance means the portion of the Covered Charges which the insured is required to pay after the Deductible before benefits are payable for any benefit that has a coinsurance requirement. The Coinsurance Limit is shown in the schedule.

Copayment or Copayment Amount means the specified dollar amount of Covered Expenses that must be paid by an Insured Person before benefits are payable under the Policy or Rider that has a Copayment Amount.

Covered Charges means that portion of the charge allowed by the Policyholder's Major Medical Plan for medically necessary expenses which are specified, described and limited in the Policy or Rider for which benefits are payable under the Policy as the result of covered Injury or Sickness.

Deductible means that portion of the Covered Charges, incurred during the Benefit Year, which an Insured Person is required to pay before benefits are payable for any Benefit that has a Deductible requirement. The Deductible amount is shown in the Schedule.

Effective Date means the date insurance begins under the Policy. Insurance will begin as of the first or the fifteenth of the month, as stated on Page one (1) of the Policy, following Our approval and payment of the first premium. In no event will coverage for any person become effective prior to the Policy Effective Date.

Eligible Person means a person who is insured under the Policyholder's Major Medical Plan and who meets the criteria described in the Policy as eligible for insurance. (See the Eligibility Section of the Policy – page 7)

Injury means bodily harm caused by an accident resulting in trauma. A disease must not directly cause the bodily harm.

Insured Person means either an Insured or the dependent of an Insured who is covered by the Policyholder's Major Medical Plan and whose coverage under this Policy has become effective and has not been terminated.

Major Medical Coinsurance means that portion of the Covered Charges an Insured Person is required to pay after the Major Medical Deductible under his/her Major Medical Plan.

Major Medical Deductible means that portion of the Covered Charges an Insured Person is required to pay before benefits are payable under his/her Major Medical Plan.

Major Medical Facility Copay means a pre-determined amount of the Covered Charges an Insured Person is required to pay before benefits are payable under his/her Major Medical Plan for services rendered in a hospital, surgical facility, imaging facility, urgent care facility, emergency room, rehabilitative facility, or laboratory. It does not include the copays for Physician office visits or prescription drugs.

Major Medical Plan means a written benefit plan, maintained by the Policyholder that has a Major Medical Deductible and/or Major Medical Coinsurance provision, funded through insurance or otherwise, that provides minimum essential coverage as required by state and federal laws.

Maximum Out-of-Pocket means the amount of Covered Charges that an Insured Person, or an Insured Person's Family must pay in a Benefit Year, before benefits will be payable at 100% for that Benefit Year.

Maximum Total Benefit Amount means the maximum dollar amount of benefits payable during any one (1) Benefit Year on account of all Covered Charges incurred during that Benefit Year by any one (1) Insured under the Policy, the Certificate and all Riders attached to and made a part of the Policy and the Certificate. The Maximum Total Benefit Amount is shown in the Schedule. The Maximum Total Benefit Amount can never exceed the Maximum Out-of-Pocket of the Policyholder's Major Medical Plan.

Outpatient means a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment.

Physician means a person who is licensed to practice medicine; and renders treatment within the scope of that license; and is not an immediate relative by blood or marriage to the Insured Person.

Policy means the Policy of insurance that We have issued to the Policyholder.

Policy Date means the date shown as Policy Date on Page one (1) of the Policy.

Policyholder means the employer or organization named as Policyholder on Page one (1) of the Policy.

Policy Year means the one (1) year period beginning on the Policy Date and ending on the last day of the twelfth (12^{th}) month following the Policy Date.

Schedule means a page in the Policy/Certificate, which outlines benefit amounts, maximums, and limitations, for Insured Persons.

Sickness means an Insured Person's illness, disease or condition, including all related complications and recurrences that occur while the Insured Person's coverage is in force.

You or Your means the Policyholder as defined.

GENERAL PROVISIONS

Entire Contract
The Policy, the Policyholder's Application, Certificates of Coverage, all Insured's eligibility information, and any endorsements and/or riders, is the entire contract between the Policyholder and the Company. All statements made by the Policyholder, in the absence of fraud, will be deemed representations and not warranties. No such statement will void the insurance or reduce the benefits under this Policy or be used in defense of a claim unless it is contained in a written application and a copy is provided to the Insured Person or beneficiary. No change in this Policy will be valid until approved by one of Our officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

Major Medical Requirement
The Policyholder must maintain a Major Medical Plan which meets the minimum essential benefit requirements of applicable state and federal laws in order for benefits to be paid under this policy.

Conformity with State Statutes
Any provision of the Policy that, on its Effective Date, is in conflict with the laws of the state in which the Policy is issued is amended to conform to the minimum requirements of such laws.

Certificates
We will issue Certificates to be provided by the Policyholder to each Insured. The Certificate will describe: the benefits to which each Insured Person is entitled under the Policy; to whom such benefits are payable; the limitations, exclusions and requirements of the Policy.

Policy Inspection
The Policy may be inspected by the Insured or the Insured's dependent at any time during the regular business hours of the Policyholder.

Policy Amendments Provision
Subject to the laws of the state in which the Policy is issued, it may be changed at any time by written amendment agreed to by the Policyholder and Us. Premium rates may be changed according to the "Premiums" section. Any amendments to the Policy will be binding on all Insured Persons, whether an Insured Person was insured prior to or after the Effective Date of the amendment.

Legal Actions
No action at law or in equity shall be brought to recover under this Policy prior to the expiration of sixty (60) days after written Proof of Loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of the two (2) years after the time written Proof of Loss is required to be furnished.

Misstatement of Sex or Age
If relevant facts supplied to Us about an Insured Person were not accurate, an adjustment of premium will be made and the true facts will decide in what amount insurance is valid under this Policy.

Clerical Error Provisions
Clerical error or delays in keeping records for the Policy:

1. Will not deny insurance, which would otherwise have been granted;
2. Will not continue insurance which would otherwise have ceased; and
3. Will call for an adjustment of premiums or benefits to correct the error.

Workers' Compensation or Workmen's Compensation Not Affected
The Policy is not in place of and does not affect any requirements for coverage by Workers' Compensation Insurance or Workmen's Compensation Insurance.

Physical Examination
The company at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Extension of Benefits:
Upon termination of insurance, an Extension of Benefits shall be provided under the Group Policy in the event of total disability of the Insured at the date of discontinuance of this insurance.

1. This Extension of Benefits shall apply if all of the following apply:
   a. The treatment was recommended in writing and commenced, in connection with a specific accident or sickness incurred while the policy was in effect, by the attending physician to the patient while the patient was covered under the policy.
   b. The treatment was performed within 90 days after the patient's coverage ceased under the Policy and the termination of coverage did not occur as a result of the patient's, or, in the case of a dependent child, the child's parent's, voluntary termination of coverage.
2. This Extension of Benefits terminates upon the earlier of:
   a. The end of the 90-day period specified in item 1.b. as noted above.
   b. The date the patient becomes covered under the succeeding policy or contract providing similar coverage.
3. If coverage for treatment referred to in item 1.a. is excluded by the succeeding policy or contract through the use of an elimination period, the patient is not covered by the succeeding policy or contract and the extension of benefits does not terminate.
4. All policy or contractual limitations, exclusions, or reductions that would have applied to the specific treatment had the coverage on the patient not terminated apply during the Extension of Benefits.

PREMIUMS

Premiums must be paid on time to keep this Policy in force. This section explains how and when premiums are to be paid.

Payments
Premium payments are payable at Our Administrative Office or to Our designated agent. The first premium is due on the Effective Date. Each subsequent premium is due on the first day following the interval for which the preceding premium was paid.

Right to Change Premium
We reserve the right, at any time and from time to time, to change all premiums applicable to the Policy and/or any Rider that is made a part of it on any premium due date by giving written notice to You and the Policyholder at least sixty (60) days in advance of the date premium is to be changed.

Grace Period
We will allow a period of thirty-one (31) days after the premium due date for payment of each premium. The Insured's coverage is active during this period. However, the payment of claims for dates of service during the time period for which premiums are due, will be paid until payment is received.

RENEWAL AND TERMINATION

The Policy, and any Rider that is made a part of it, is renewable at Our option and with Our consent may be renewed from month to month by payment of the applicable premium. We may terminate the Policy, and any attached Rider under certain conditions by giving at least ninety (90) days written notice to the Policyholder. The Policyholder may terminate the Policy and any Rider by giving written notice to the Company.

ELIGIBILITY

Eligible Person as used in this Policy means a person who is insured under a Major Medical Plan maintained by the Policyholder

(TRICARE, Medicare or Medicaid is not a Major Medical Plan) and who is:

Eligible Person -

1. An employee of the Policyholder who is insured under the Policyholder's Major Medical Plan;
2. An employee's dependent spouse or dependent children (see definition of "Insured Person") who are insured by the Policyholder's major medical plan.

Eligible new employees or dependents may be added subject to the terms of this Policy.

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" provision of the Policy.

STANDARD BENEFIT PROVISIONS

Benefits Payable - Benefits provided by this Policy and any Rider are those:

1. Described in this Policy or on a Rider; and
2. Shown on the Schedule; and
3. For which premiums are paid.

Riders (if any) issued and made a part of this Policy are listed in the Schedule.

Medical Benefit

After the Insured Person's Deductible, Coinsurance or Copayment (if any) shown on the Schedule have been met, We will pay the benefits shown in the Schedule for:

If selected by the Policyholder on the Application and as indicated in the Schedule, the Covered Charges for expenses charged by the provider and not paid by the Policyholder's Major Medical Plan because the expenses have been applied to the Major Medical Plan's Deductible; and

If selected by the Policyholder on the Application and as indicated in the Schedule, the Covered Charges for expenses charged by the provider and not paid by the Policyholder's Major Medical Plan because the expenses have been applied to the Major Medical Plan's Coinsurance; and

If selected by the Policyholder on the Application and as indicated in the Schedule, the Covered Charges for expenses charged by the provider and not paid by the Policyholder's Major Medical Plan because the expenses have been applied to the Major Medical Facility Copay; but

We will not pay more than the Maximum Total Benefit Amount shown in the Schedule. All benefits are subject to the "Exclusions and Limitations" provision of the policy.

Outpatient Physician's Expense Benefit

We will pay the benefits shown in the Schedule, when:

1. An Insured Person receives medically necessary treatment from a Physician in the Physician's Office or Clinic; and
2. An Insured Person incurs expenses that are covered by the Policyholder's Major Medical Plan; and
3. The Covered Charges are applied to the Deductible and/or Coinsurance by the Policyholder's Major Medical Plan.

First Calendar Year Deductible Credit

Charges incurred by an Insured Person under the Policyholder's Major Medical Plan, up to the Deductible amount shown in the Schedule, that have been applied to the Major Medical Deductible prior to the Effective Date of the Policy, will be credited to the Insured Person's annual Deductible after deduction. This applies only during the first Year the Policy takes effect. Credit will not be provided to anyone who becomes insured after the effective date of the Policy.

Limitation Applicable to All Benefits including Rider Benefits

We will not pay during any Year, any amounts otherwise payable, that are subject to the Deductible, Coinsurance or Copayment amounts (if any), or that exceed the Total Maximum Benefit Amount shown on the Schedule.

The Total Maximum Benefit Amount shown in the Schedule will never exceed the Maximum Out-of-Pocket Amount of the Policyholder's Major Medical Plan for an Insured Person or their Dependents.

EXCLUSIONS AND LIMITATIONS

The Policy will pay no benefits for any expenses which result from:

1. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly (This does not include a loss which occurs while acting in a lawful manner within the scope of authority.);
2. Commission of a felony;
3. An act of war, whether declared or undeclared while serving in the military service or any auxiliary unit attached thereto, or while performing police duty as a member of any military or naval organization.
   This exclusion includes Accident sustained or Sickness contracted while in the services of any military, naval, or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Persons is not covered;
4. Accident or Sickness arising out of and in the course of any occupation for compensation wage or profit. This does not apply to sole proprietors not covered by Workers' Compensation;
5. Professional fees for services performed in a doctor's office or medical clinic unless specified as a covered charge in the Schedule of Benefits.
6. Outpatient prescription drugs.
7. Any dental services, except for dependent children, including treatment, surgery, extractions, or x-rays, unless: (a) Resulting from an Accident occurring while the Covered Person's coverage is in force and if performed within 12 months of the date of such Accident; or (b) Due to congenital disease or anomaly of a covered newborn child;
8. Any expenses incurred, except for dependent children, for eye exams, eye refractions, eye glasses, contact lenses, or the fitting thereof, or elective surgery performed for the correction of vision;
9. Any expense for which benefits are not payable under the Covered Person's Other Medical Plan;
10. Any expense that does not meet the definition of Covered Charges;
11. Any additional expense or penalty imposed by the Major Medical Plan for failure of the Insured to receive prior authorization under the Major Medical Plan;
12. Expense or service that exceeds the Maximum Total Benefit Amount, as shown in the Schedule of Benefits.

TERMINATION OF COVERAGE

Coverage will terminate under this Policy and any Riders on the earliest date that any of the following events occur:

1. For the Insured:
    a. On the date the Policy terminates;
    b. As of the premium due date when the required premium remains unpaid, subject to the Grace Period as defined in the policy;
    c. On the premium due date following the date the Insured ceases to be an Eligible Person as defined in the Policy;
2. For the Insured Dependents:
    a. On the date the Insured's coverage terminates;
    b. As of the premium due date when the required premium for the Dependents and or spouse remains unpaid, subject to the Grace Period;
    c. On the premium due date following the date the Insured Dependent ceases to be an Eligible Person.

If a mental or physical disability prevents an unmarried dependent child from self-support when he or she reaches the termination age, he or she may remain insured under the Policy. Proof of such incapacity and dependency must be furnished to Us within thirty-one (31) days of the child's attainment of the termination age and not more frequently than annually thereafter. Coverage will continue as long as the Insured's coverage remains in force, premiums for the Insured Dependent child are paid, and the Insured Dependent child is incapable of self-support.

An unmarried dependent may remain insured under the Policy until the dependent's 30th birthday if the dependent (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge. To be eligible for coverage under this subsection (d), the eligible dependent shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

An unmarried dependent may remain insured under the Policy until the dependent's 26th birthday.

Termination of the insurance will be without prejudice to any claim incurred before the date of termination.

CLAIM PROVISIONS

Notice of Claim

Written notice of claim must be given to insurer within twenty days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at our Administrative Office or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. Notice must include the name of the Insured Person, the Policy/Certificate number and nature of the loss.

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of claim, give to the company notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the company on account of such claim or any denial of liability in whole or in part by the company shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given

Proof of Loss

Electronic proof of loss may be submitted by the provider of services as a secondary payer claim. The electronic claim must include the Insured's Major Medical Plan payment information. Written proof of loss may be given to Us ninety days (time required) after the occurrence or commencement of any covered loss. Proof of loss must include a copy of the Insured's explanation of benefits (EOB) provided by the Insured's Major Medical Plan along with either the UB 04 or CMS 1500 provided by the provider. If it is not reasonably possible to give Us written Proof of Loss in the time required, We will not reduce or deny the claim for this reason alone, if the Proof of Loss is filed as soon as reasonably possible. Nonetheless, unless the Insured is legally incompetent, the Proof of Loss must be provided to Us within one (1) year of the time required.

Time of Payment of Claims

Any benefit payable under the Policy will be paid not more than 30 days after the Company receives proper written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. Failure to pay within such period shall entitle the Insured to interest at the rate of 9% per annum from the 30th day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

Payment of Claims
All benefits will be payable to the Insured, unless We receive written Assignment of benefits to the provider of covered services. Any accrued benefits unpaid at the Insured's death will be paid to the Insured's estate in an amount not to exceed $1,000.

CONTINUATION OF COVERAGE

Family and Medical Leave Act of 1993 (FMLA) - Continuation of Benefits
(Applies to employers with 50 or more employees)

Insureds who have been employed by the Policyholder for at least 12 months and who have performed at least 1,250 hours of work during that period are entitled to 12 work weeks of leave during any 12-month period for one or more of the following reasons:

- the birth of a child to the Insured;
- the placement of a child with the Insured for adoption or foster care;
- to care for the spouse, child or parent of the Insured if such person has a serious health condition; or
- a serious health condition makes the Insured unable to perform the main functions of his or her employment.

An Insured on FMLA leave may continue benefits for the duration of that leave under the same conditions as applied prior to the leave. The terms of the FMLA supersede state family medical leave laws for employers of 50 or more employees insofar as the FMLA provides greater family or medical leave rights than those established by the state law.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

An Insured who is absent from work due to a period of duty in the uniformed services may have the right to continue benefits for himself and his Insured Dependents in accordance with USERRA provisions. The Insured must pay the required monthly premium for the continued coverage to the employer.

COBRA

Continuation of Benefits in Accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (Applies to employers with 20 or more employees).

Applicability
Federal law requires that employers of 20 or more employees for at least 50% of the preceding year, offer a temporary extension of health coverage to Qualified Beneficiaries when coverage would otherwise end because of the occurrence of one or more of Qualifying Events listed below. Under COBRA, a Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is covered under the Policy and is not already covered under the Policy by reason of another individual's election of COBRA.

Qualifying Event
For purposes of coverage under COBRA, the term "Qualifying Event" means, with respect to any Insured Person, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage for a Qualified Beneficiary.

Qualifying Events	**Duration of Continued Coverage**
1. Death of an Insured	36 months
2. Termination of employment for any reason except gross misconduct, or the reduction in hours that would result in loss of coverage	18 months*
3. Divorce or legal separation	36 months
4. Insured becomes eligible for Medicare	Dependents and spouse allowed 36 months
5. Insured Dependent no longer meets Insured Dependent eligibility requirements	36 months

*Coverage may be continued an additional 11 months if the Qualified Beneficiary:

1. is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
2. notifies the plan administrator within 60 days from determination (but before the 18 month continuation period ends).

Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total continuation period exceed 36 months for all Qualifying Events.

Notice and Election
Insured Persons are responsible for notifying the employer in the case of a divorce, legal separation, cessation of dependency or determination of disability by the Social Security Administration. The employer must notify the plan administrator of the Qualifying Event. The employer must notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of (a) the date on which coverage terminates under the Policy by reason of a Qualifying Event, or (b) the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

Premium Payment

The Qualified Beneficiary must pay to the employer the required monthly premium. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of election.

COBRA Termination occurs at the earlier of:

1. the premium for continued coverage is not paid within 31 days from being due;
2. the Qualified Beneficiary becomes covered under another group medical plan, if that plan does not contain any exclusion or limitation on any Pre-existing Conditions of the Qualified Beneficiary;
3. the Qualified Beneficiary becomes eligible for Medicare;
4. the Qualified Beneficiary, who is divorced from an Insured Employee, remarries and is covered under the new spouse's medical plan; or
5. the employer no longer provides medical benefits of any kind.

Employee Retirement Income Security Act of 1974 (ERISA)

The Policyholder has established and maintains an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended, to provide the benefits described in the Policy to its employees and their dependents. These benefits are insured by the Company under the Policy, which the Policyholder endorses. The Policyholder is the Plan Administrator, Plan Sponsor, named fiduciary, and, if applicable, Plan Trustee, for the Plan. For more information about the plan, consult the Policy. ERISA does not apply to certain plans, such as government plans and church plans.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

This group health plan provides benefits to plan participants and their dependents as required under WHCRA. Benefits will be paid as any other covered illness or injury as specified in the Policy Schedule.
Coverage is provided for the following services relating to a mastectomy as determined in consultation with an attending physician.

- 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 at all stages of the mastectomy, including lymphedema.

Compliance with Illinois Bulletin 2011-06 and The Religious Freedom Protection and Civil Union Act

Company recognizes the rights afford to individuals under The Religious Freedom Protection and Civil Union Act which states: "The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married." or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

ILLINOIS
LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(773) 714-8050

Illinois Department of Insurance
320 West Washington Street
4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary of General Purposes And Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") [215 ILCS 5/531.01, et seq.]. The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

a. Coverage:
The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

1. life insurance, health insurance, and annuity contracts;
2. life, health or annuity certificates under direct group policies or contracts;

3. unallocated annuity contracts; and
4. contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

b. Exclusions from Coverage:
   1. The Guaranty Association does not provide coverage for:

      A any policy or portion of a policy for which the individual has assumed the risk;
      B any policy of reinsurance (unless an assumption certificate was issued);
      C interest rate guarantees which exceed certain statutory limitations;
      D certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
      E any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
      F any stop loss insurance.

   2. In addition, persons are not protected by the Guaranty Association if:
      A the Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
      B their policy was issued by an organization which is not a member insurer of the Association.

c. Limits on Amount of Coverage:

   1. The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:

      A the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
      B with respect to any one life, regardless of the number of policies, contracts, or certificates:

         (a) in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values;
         (b) in the case of health insurance, $300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
         (c) with respect to annuities, $100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000 in benefits per contract holder, regardless of the number of contracts.

   2. However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

AmFirst Insurance Company

PRIVACY NOTICE

At AmFirst Insurance Company, we understand the level of trust you have placed with us to protect your personal information. This notice explains how we protect your privacy and treat your personal information. This notice applies to current and former customers. "Personal information" here means anything we know about you personally.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential and tell our employees to protect it as if it were their own information. We limit access to those who need it to perform their jobs. Our outside service providers must also protect your information, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. For example, we may ask about your:

- Finances
- Creditworthiness
- Employment
- Health

We may also collect information about any business you have with us, our affiliates, or other companies. These affiliates have implemented privacy policies and procedures that comply with applicable federal and state law. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- Administer your products and services
- Process claims and other transactions
- Perform business research
- Confirm or correct your information
- Market new products to you
- Help us run our business
- Comply with applicable laws

Sharing Your Information with Others

We may share your personal information, with your consent, or as permitted or required by law. Examples of the disclosures which we are permitted by law to make include: disclosures necessary to service or administer an insurance product that you requested or authorized, disclosures made with your consent or at your direction, disclosures made to your legal representative, disclosures made in response to a subpoena or an inquiry from an insurance or other regulatory authority, disclosures made to comply with federal, state or local laws and to protect against fraud.

Other reasons we may share your information include:

- Doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- Telling another company what we know about you if we are selling or merging any part of our business
- Giving information to a governmental agency so it can decide if you are eligible for public benefits
- Giving your information to someone with a legal interest in your assets (for example, creditor with a lien on your account)
- Those listed in our "Using Your Information" section above

Additionally, your representative may change brokerage firms, and may disclose your personal information to a new firm.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside AmFirst.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:
AmFirst Insurance Company
Attn: Privacy Officer
P.O. BOX 16708
Jackson, MS 39236
Phone: 888-538-6941

We may revise this privacy notice. If we make any material changes, we will notify you as required by law.

A copy of this privacy notice is available online at
https://morganwhite.com/privacy

Effective Date: January 1, 2019.

NOTICE OF PRIVACY PRACTICES

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

Our Legal Duty

This notice is required by law to tell you how AmFirst Insurance Company ("AmFirst") protects the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's medical/dental history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. AmFirst may receive, use and disclose your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI is prohibited.

We must follow the privacy practices described in this notice. However, we may change this notice and make the new notice effective for all of your PHI we maintain. If we make any substantive changes to our privacy practices, we will promptly change this notice and redistribute to you within 60 days of the change to our practices. You may also request a copy of this notice from the privacy official at the plan headquarters which provides your benefits (refer to the Contact section at the end of this notice). You should receive a copy of this notice at the time of enrollment in an AmFirst program, and we will notify you of how you can receive a copy of this notice every three years.

Permitted Uses and Disclosures of Your PHI

We are permitted to use or disclose your PHI without prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit program is sponsored by your employer, we may provide PHI to your employer for purposes of administering your benefits. We may disclose PHI to third parties which perform services for AmFirst in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate performing services for AmFirst in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information

about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you.

Additionally, we may use and disclose your medical information without your permission, for health care operations which include:

- Health care quality assessment and improvement activities
- Reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities
- Conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention
- Underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations (although we are prohibited from using or disclosing any genetic information for these underwriting purposes)
- Business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research

Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers. Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.
  For example, we may use or disclose your PHI to determine eligibility for services requested by your provider.

- Uses and/or disclosures of PHI for payment.
  For example, we may use and disclose your PHI to bill you or your plan sponsor.

- Uses and/or disclosures of PHI for health care operations.
  For example, we may use and disclose your PHI to review the quality of care provided by our network of providers.

Disclosures AmFirst Must Make Without an Authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine our compliance with law, and when otherwise required by law.

We must disclose your PHI without your prior authorization in response to the following:

- Court order
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority
- Subpoena in a civil action
- Investigative subpoena of a government board, commission, or agency
- Subpoena in an arbitration
- Law enforcement search warrant
- Coroner's request during investigations

Disclosures AmFirst Makes With Your Authorization

AmFirst will not use or disclose your PHI without prior authorization if the law requires your authorization. You can later revoke the authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by AmFirst or by a person requesting your PHI from AmFirst.

Individual Rights

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting AmFirst at the address listed below. You must include your name, address, telephone number and identification number and the PHI you are requesting. AmFirst may charge a reasonable fee for providing you copies of your PHI. AmFirst will only maintain the PHI we obtain or utilize in providing your health care benefits. Most PHI, such as treatment records or X-rays, is returned by AmFirst to the provider after we have completed our review of the information. You may need to contact your health care provider to obtain the PHI AmFirst does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact AmFirst at the address listed below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask AmFirst to limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures we are legally required or allowed to make.

You have the right to correct or update your PHI. You may request an amendment of PHI about you for as long as we maintain this information. In certain cases we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement. We may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal. If your PHI was sent to us by another entity, we may refer you to that entity to amend your PHI. For example, we may refer you to your provider to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact AmFirst at the address listed below if you have questions about amending your PHI.

You have the right to request or receive confidential communication from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide a statement of possible danger, a different address, another method of contact, or information as to how payment will be handled. Please make this request in writing to AmFirst at the address listed below.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information disclosed after a valid authorization was received from you. Additionally, we do not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact AmFirst at the address listed below if you would like to receive an accounting of disclosures or if you have questions about this right.

You have the right to receive this notice by E-Mail. You have the right to receive a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

Nonpublic Personal Financial Information

Except as explained below, AmFirst restricts access to nonpublic personal information about an individual to our employees, who need to know what information or products and services to provide. We maintain physical, electronic, and procedural safeguards which comply with federal and state regulations to guard nonpublic personal information.

We collect nonpublic personal information about you, submitted by you, on applications or other forms and information about your transactions with us, our affiliates or others.

We may disclose all the information we collect as described above.

We may share this information with affiliated companies and nonaffiliated third parties to perform services or functions on our behalf. Otherwise, we do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted

by law. When we make disclosures of nonpublic personal information, except for those disclosures permitted by law, we require non-affiliated third parties to protect the confidentiality of such information and to use it solely for the purpose for which we disclosed the information.

Questions & Complaints

For more information about our privacy practices or if you have questions or concerns, please contact us using the information at the end of this notice.

You may submit a complaint to us or to the U. S. Secretary of Health and Human Services if you believe AmFirst has violated your privacy rights. You may file a complaint by notifying AmFirst at the address listed below. We support your right to the privacy of your medical information. We will not retaliate in any way if you chose to file a complaint with us or U.S. Secretary of Health and Human Services.

You may contact AmFirst at the address and telephone number listed below for further information about the complaint process or any information contained within this notice.

AmFirst Insurance Company
Attn: Privacy Officer
Post Office Box 14067
Jackson, MS 39236-4067
800-800-1397

This notice is effective on and after January 1, 2016.

Application for
Premium Saver Insurance

201 Robert S. Kerr Ave., Suite 600
Oklahoma City, OK 73102

Administrative Offices:
P.O. Box 14067
Jackson, MS 39236

AmFirst
Insurance Company

Company Information

The information provided by the applicant in this application will be the basis on which any insurance is issued. Incorrect information could void insurance.

Legal name of employer (include d/b/a) Multiplex Display Fixture Company dba The Miller Group	Employer identification number 43-0426150
Principal business or activity manufacturer	SIC code 2542
Physical address 1610 Design Way	
City Dupo — State IL	Zip 62239

Contact/Billing Information

If bill is to be split and sent to more than one billing address please indicate in the "Second Billing Address" section below.

Billing address 1610 Design Way	
City Dupo — State IL	Zip 62239
Executive contact full name Karen Poole	Title EVP
Telephone number 636-343-5700	Fax number 636-764-0670
Email address karenpoole@miller-group.com	
Billing contact full name Patrick Mohen	Title Accounting Clerk
Telephone number 636-343-5700	Fax number 636-764-0675
Email address ap@miller-group.com	
HR contact full name Karen Poole	Title EVP

Second Billing Address *(if necessary)*

Billing address		
City	State	Zip

Plan Design

Employer's Major Medical or Comprehensive Plan Data		
Major medical plan carrier UHC	Major medical deductible amount $ 5,000 (2x Family)	Major medical coinsurance *(percentage and amount)* 60%/40% and $ 3150
Major medical maximum out-of-pocket (MOOP) amount $ 8150 (2x family)	Are major medical deductibles & coinsurance ☐ Plan Year ☑ Calendar Year	Major medical plan anniversary date 4/1/24
Eligibility		
Eligible person as used in the policy means a person who is insured under a group major medical plan or comprehensive health plan (CHAMPUS/TRICARE or Medicaid is not a comprehensive medical plan). Eligible new employees or dependents may be added subject to the terms of the policy.		Total # of eligible employees 15
Employer's waiting period: ☑ 1st of the month following 60 days ☐ 1st of the month following date of hire ☐ After _____ days of employment ☐ 15th of the month following _____ days	☐ Date of hire ☐ Other (please explain) _____	
Premium Saver Plan Design		
Request effective date 4/1/23	Benefit year ☐ Plan Year ☑ Calendar Year	Deductible $ 3000 EE _____ Family
Coinsurance *(percentage and amount)* 0 % and $ 0	Maximum total benefit amount $ $5000	Maximum out-of-pocket $ 3000
Copayment amount ☐ Yes ☑ No $ _____	Major medical covered charges ☒ Deductible ☒ Coinsurance ☐ Copay ☒ Occurrence Copay	
Outpatient physician's expense benefit *(copayment amount and maximum number of visits)* ☐ Yes ☑ No $ _____ Visits _____	Insurance Cards are sent to employee's home address unless otherwise notated in comments below. Comments: _____	

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" provisions of the policy.

Additional Comments:

Agreements, Representations and Understanding

On behalf of the Employer, I represent the following: 1) That all statements made herein are complete and true as of the date I signed this Application; 2) That I have read and understand this form; 3) That AmFirst Insurance Company (AmFirst) will rely on these statements and this information as the basis for approving this Application; and 4) That 100% of eligible employees and dependents will be enrolled in the Premium Saver Plan.

On behalf of the Employer, I understand the following: 1) That the Premium Saver Insurance Policy for which Employer is applying is a Supplemental Policy that pays only the benefits selected and set forth in the Policy itself. Our agent has explained the Policy's limitations and exclusions, if any; 2) That only those employees and dependents covered under our company's major medical or comprehensive health plan are eligible for coverage. Important Note: All persons (100% participation) insured by the Employer's Major Medical or Comprehensive Health Plan must be insured by the Premium Saver Plan. Exception – employees funding an HSA account are not required to participate and cannot be covered by this plan; 3) That coverage is effective when: a) the Policy is issued by AmFirst; b) the Policy is received and accepted by the Employer; and c) the full first premium is paid and accepted by AmFirst; and 4) That the Employer or AmFirst may terminate the Policy and any Rider(s) on any premium due date by giving at least (90) days written notice to the other party. The Policyholder is responsible for notifying the Insureds of the termination or non-renewal of the Policy.

The Employer agrees to make any necessary payroll deductions for any employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. The Employer requests the Administrator for AmFirst to bill the Employer for all premiums and any applicable administrative fee due under the Insurance Policy issued.

By my signature below, Employer agrees to assume any duty, responsibility, or obligation necessary to satisfy any reporting or tax requirements for this Employer under the Employee Retirement Income Security Act of 1974 (ERISA) or any other Local, State or Federal laws which may arise for any reason related to the insurance provided for or made available to employees by the Employer.

On behalf of the Employer, I acknowledge and understand that any misrepresentation on this Application by Employer's agent or me may result in the cancellation or rescission of any Policy issued based on this Application.

On behalf of the Employer, **I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this Application for the Employer's state of domicile.**

On behalf of the Employer, this Application for Group Insurance is signed by

Signature: Karen Poole Print name: Karen Poole

Official title: EVP Date: 04/10/23

Agent signature: Kelly L Rector Print name: Kelly Rector

Agent license number: NPN: 5058809 Lic# 277851