Ben E. Keith Company

2022 Summary Plan Descriptions

A guide to your 2022 Ben E. Keith Company benefits plans

We've created this Summary Plan Description (SPD) to make it easy to quickly find the benefits information you need. This SPD is also available any time in the *Plan documents & policies* section of bek.family.

Visit bek.family any time for more information

Learn about your Ben E. Keith Company benefits

This document includes the Summary Plan Descriptions (SPDs) for each of your Ben E. Keith benefit plans. Please take time to review each SPD to understand your benefits.

All benefits are subject to eligibility, payment of premiums, limitations and all exclusions outlined in the applicable Plan documents, including any insurance policies. You can request a copy of the governing Plan documents by sending an email to benefits@benekeith.com.

Information obtained during calls to Ben E. Keith Company or to any Plan provider or carrier does not waive any provision or limitation of the plan. Information given or statements made on a call or in an email do not guarantee payment of benefits.

Este documento incluye las Descripciones resumidas del plan (SPD) para cada uno de sus planes de beneficios de Ben E. Keith. Favor de tomarse el tiempo para repasar cada SPD para entender sus beneficios.

Todos los beneficios están sujetos a la elegibilidad, el pago de las primas, las limitaciones y todas las exclusiones descritas en los documentos del Plan correspondiente, incluidas las pólizas de seguro. Puede solicitar una copia de los documentos que rigen el Plan enviando un correo electrónico a benefits@benekeith.com.

La información obtenida durante las llamadas a Ben E. Keith Company o a cualquier proveedor o compañía del Plan no renuncia a ninguna disposición o limitación del Plan. Información dada o declaraciones hechas en una llamada o en un correo electrónico no garantizan el pago de los beneficios.

A quick look at your benefits

If you meet the eligibility requirements described in the **Eligibility and enrollment** chapter, you can participate in any of these plans and programs. You must enroll and make the necessary payroll deductions for your coverage to become effective.

Medical
Choose from the BEK PPO or BEK HSA Medical Plan.

Both plans include prescription drug benefits and wellness programs.

HSA (Health Savings Account)
Enroll in the BEK HSA Medical Plan to open an HSA with Optum Bank.

Receive Company contributions to help pay for medical, dental or vision expenses.

Dental
Get routine dental care, X-rays, basic and major care.

Company-paid Basic Life/AD&D
Eligible employees receive $50,000 in basic life/AD&D coverage at no cost.

Vision
Choose coverage for yourself and your family members and receive regular eye exams, glasses and contacts.

Flexible Spending Accounts
Use pre-tax dollars to pay for eligible dependent and health care expenses.

Supplemental employee, spouse, and child life/AD&D
Additional coverage is available for you and your dependents.

STD (Short-term disability)
Ben E. Keith provides STD coverage to replace a portion of your pay for the first 26 weeks of personal illness or injury.

LTD (Long-term disability)
Ben E. Keith provides LTD coverage so you have income after your STD benefits end and you can't work for an extended period of time due to a non-work-related illness or injury.

Employee Assistance Program
No-cost, 24/7 confidential support for you and your family.

Eligibility and enrollment

You are eligible to participate in the Ben E. Keith Company benefits plans described in this SPD if you are a full-time employee who is scheduled to work at least 30 hours per week. Part-time employees can also enroll in certain benefits as noted in the following chart.

What you need to know:

- Newly-hired employees who want coverage MUST enroll in benefits by the first day of the month following 60 days of employment (or the first day of the month following 30 days of employment for Southeast Division or Kelley Manufacturing employees). Otherwise, you must wait until the next Annual Enrollment period.
- If you are a Ben E. Keith employee and enroll in benefits, your coverage begins on the first day of the month following your 60th day of employment.
- If you are a Southeast Division or Kelley Manufacturing employee and enroll in benefits, your coverage begins on the first day of the month following your 30th day of employment.
- Coverage for your enrolled dependents generally begins when your coverage begins. However, you must return the requested documentation to prove you are covering eligible dependents within 60 days (or 30 days for Southeast Division and Kelley Manufacturing employees).

Eligible employees

Eligible employees include:	Benefits you are eligible to enroll in include:
• Hourly full-time employees who work at least 30 hours per week. • Salaried or commissioned employees	• Medical • Health Savings Account • Flexible Spending Accounts • Dental • Vision • Basic life/AD&D • Supplemental employee, spouse and child life/AD&D
• Part-time employees who work less than 30 hours per week	• Medical • Health Savings Account • Flexible Spending Accounts • Dental • Vision

Eligible dependents

You may enroll the following dependents in coverage:

- Your spouse. If you and your spouse are both Ben E. Keith employees, you can enroll as a dependent or as a primary insured person, but not both.
- Your children or your spouse's children, up to age 26, including a natural child, stepchild, legally adopted child, foster child, natural grandchild for whom you have legal guardianship, a child placed for adoption, or a child your spouse is the legal guardian of.
- An unmarried child age 26 or older who is incapable of self-care due to a medical or physical disability.
- A child you are required to provide coverage for, due to a Qualified Medical Child Support Order, or any other court or administrative order.

Who is not eligible

You are not eligible to participate in the Ben E. Keith benefits plans if you are:

- An independent contractor.
- A leased employee.
- A temporary employee.

When coverage begins

You must be actively employed on the day your benefit plan participation begins. If you are not on active, full-time status on that day, your participation will be delayed until you return to full-time, active status.

- **Hourly employees** (full-time or part-time). Coverage begins on the first day of the month that is on or after the date that he or she completes 60 days of continuous employment (or 30 days of continuous employment for Southeast Division and Kelley Manufacturing employees).
- **Salaried employees**. Coverage begins on the first day of the month that is on or after the date that he or she completes 60 days of continuous employment (or 30 days of continuous employment for Southeast Division and Kelley Manufacturing employees).
- **Rehired employees**. If you are rehired within 30 days of termination, you will automatically be re-enrolled in the same coverage you had prior to termination.

Coverage for eligible dependents

You may enroll your eligible dependents in:

- Medical, dental and vision coverage
- Supplemental spouse life/AD&D
- Child life/AD&D coverage

Refer to *How coverage begins and ends* in the **BEK Medical Plans & prescription drugs** chapter for more information about the certification of a disabled child.

IMPORTANT! You must enroll within 60 days of your hire date (or 30 days if you are a Southeast Division and Kelley Manufacturing employee).

If you do not enroll in the benefits plans described in this SPD by the first day of the month following 60 days of employment (or the first day of the month following 30 days of employment for Southeast Division and Kelley Manufacturing employees), you cannot enroll until the next Annual Enrollment period unless you have a qualified life event during the year. Qualified life event exceptions apply only to:

- Medical, dental and vision coverage.
- Health Savings Accounts (HSAs).

Dependent documentation

You will be required to provide documentation validating your dependents' eligibility for coverage under the applicable plan when enrolling them in coverage. You must submit your documentation – e.g., marriage license, birth certificate and/or legal guardianship or adoption paperwork for child(ren) or Disabled Dependent Certification – within 60 days of enrolling him or her for coverage (or 30 days for Southeast Division and Kelley Manufacturing employees).

Find a list of acceptable dependent verification documents in the **Enroll** section of bek.family.

If a court has appointed you as the legal guardian of a dependent, you will need to certify that the dependent is a dependent of yours for federal tax purposes by submitting legal documentation following the process outlined in *Changing coverage* later in this chapter.

If you do not provide appropriate documentation within 60 days (or 30 days for Southeast Division and Kelley Manufacturing employees) of enrolling him or her for coverage, it will be assumed that your dependent is not an eligible dependent and any coverage for which he or she is enrolled will be retroactively terminated, as of his or her coverage effective date. If coverage is terminated, your dependent will not be eligible for continuation of coverage through COBRA. For more information see the *General Notice of COBRA Continuation Rights section* in the **Plan administration and ERISA rights** chapter.

If you are married to another Ben E. Keith Company employee

If you are married to another Ben E. Keith employee who is eligible for coverage, you should be aware of the following provisions when enrolling for benefits coverage:

- One of you can choose to waive medical, dental and vision coverage and be covered as an eligible dependent under your spouse's coverage.
- You may each choose "Employee Only" coverage individually.
- Only one of you may cover the other as an eligible dependent.
- Each of your children can be covered only once under the plan. That means if you both select coverage separately under the Plan, only one of you can cover a particular child.
- Neither of you may enroll in spouse life/AD&D.

How to enroll

You must enroll and pay your share of the cost of your coverage through payroll deduction contributions if you wish to participate in the following plans:

- Medical
- Health Savings Account (HSA)
- Flexible Spending Accounts (FSAs)
- Dental
- Vision
- Supplemental employee life/AD&D
- Spouse life/AD&D
- Child life/AD&D

Steps to enrollment

1. **Log in at dayforcehcm.com**
   - Enter Company code **BEKCO**, your user name (employee ID) and password.
   - Click Benefits then Start Enrollment.
   - Review the Welcome screen then select **Next**.
2. **Review and update your dependents and beneficiaries**
   - Click View/Edit.
   - Click **+** to add a dependent and/or beneficiary.
   - Select **Next** to begin your enrollment session.
3. **Choose (or waive) coverage in each benefit**
   - Your current coverage (if any) will be noted by a green checkmark.
   - Certify tobacco usage and whether you have a working spouse.
4. **Submit and save/print your enrollment confirmation**

If you forgot your password, send an email to servicedesk@benekeith.com to reset your password.

If you cover your spouse or children

If you want to enroll your dependents in medical, dental, vision and/or spouse or child life/AD&D coverage, you will be asked to provide documentation like a marriage license or birth certificate that verifies they are eligible for coverage. You must return the requested documentation by the deadline or your dependent will not have the coverage you requested.

Cost of coverage

You and Ben E. Keith share the cost of your medical, dental, and vision care coverage. You pay your share of this cost through pre-tax payroll deduction contributions.

The amount of your contribution toward the cost of your health care coverage will depend on:

- The plans you choose.
- The family members that you choose to enroll.

Tax advantages

Pre-tax dollars come out of your pay before federal income and Social Security taxes are withheld – and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

- **Health Savings Account:** If you elect to participate BEK HSA Medical Plan and open a Health Savings Account with Optum Bank, you will make your pre-tax account deposits through payroll deductions.
- **Flexible Spending Accounts:** If you elect to participate in one or both of the Flexible Spending Accounts, your account deposits are made on a pre-tax basis.

Other voluntary plans

Your costs for the following plan are paid through post-tax payroll deductions. Because these deductions are made on a post- tax basis, they will not lower your taxable income:

- Supplemental life/AD&D coverage for yourself, your spouse and/or child

Enrolling in benefits each year

Each year in the fall, Ben E. Keith conducts Annual Enrollment. You can elect to enroll, change, or cancel your election for:

- Health care (medical, dental, and/or vision)
- Health Savings Account (HSA)
- Supplemental life/AD&D for yourself, your spouse and/or children
- Flexible Spending Accounts (FSAs)

If you don't make any changes during Annual Enrollment, typically, your current benefits elections will automatically continue for all plans except the Flexible Spending Accounts and Health Savings Account. If you want to participate in these accounts, you must enroll and elect your yearly contribution amount during each Annual Enrollment period. During enrollment, Ben E. Keith may decide to utilize a default employee contribution election for the Health Savings Account. Communication regarding the default enrollment will be made prior to, and during, the enrollment period. You will have the opportunity to cancel or change the default election before it becomes effective for the following year. However, if you do not re-enroll in the HSA, no contributions will be deducted starting January 1st.

Any change you make during Annual Enrollment (for example, adding a new dependent) will go into effect on the following January 1st. This election will remain in effect for the next calendar year, unless you have a qualified life event as described in the following.

IMPORTANT: The benefits you elect during Annual Enrollment will take effect as of January 1st of the following year. You may change these elections during the year ONLY if you have a qualified life event as described later in this chapter.

Contribution amounts are subject to review. Ben E. Keith reserves the right to change your contribution amount from time to time. You can obtain current contribution rates at dayforcehcm.com.

For example, if you cancel your dental plan coverage during Annual Enrollment, this election will go into effect on January 1st and will remain in effect for the calendar year. You can't change this election until the next Annual Enrollment period, unless you have a qualified life event.

Changing your coverage during the year

In general, you cannot enroll for, change, or cancel your medical, dental, vision or life/AD&D coverage during the year unless you have a qualified life event. You also may not change your Flexible Spending Account and Dependent Care Flexible Spending Account contributions during the year, except under certain conditions. See the **Flexible Spending Accounts** chapter for more information.

The change in coverage must be consistent with the change in status (e.g., you cover your spouse following your marriage, your child following an adoption, etc.).

Note: You can change your Health Savings Account contribution amount at any time during the year, without a qualified life event.

Qualified life events

The following events are considered to be a qualified life event:

- Marriage, divorce, legal separation, annulment or death of a spouse/domestic partner.
- Birth, adoption or placement for adoption, loss of a dependent child, or appointment as a legal guardian of a child.
- A dependent no longer qualifying as an eligible dependent.
- Change in your or your spouse's employment status that affects eligibility or cost of coverage.
- Return from Leave of Absence.
- Entitlement to Medicare, Medicaid, or a state child health plan (applies only to the person with this entitlement).
- A loss of your or an eligible dependent's coverage under a Medicaid plan or a state child health plan due to loss of eligibility for that coverage.
- Change to comply with a Qualified Medical Child Support Order or a state domestic relations order.
- A change in your spouse's or child's coverage during another employer's open enrollment period when the other plan has a different coverage period or following a qualified life event under the other employer's plan.
- If you declined coverage for yourself or an eligible dependent under a Ben E. Keith medical plan because you or your dependent had other health coverage, a loss of that other coverage (applies only if the other employer stopped contributing toward the cost of that coverage).

Changing coverage

If you have a qualified life event, you have **31 days** from the date of the event to change your benefit election(s). You can make qualified changes by:

- Logging on to dayforcehcm.com and clicking *Menu* > *Benefits* > *Forms* > *Life Event Declaration*.
- Then select the date and the correct event from the *Life Event* list.
- Add any supporting documentation such as a birth certificate or marriage license.
- Click **Submit**.
- **Note:** Once the Benefits Team notifies you that your declaration has been reviewed and approved, log back on to dayforcehcm.com and click *Benefits* > *Start Enrollment* to make the election changes.

The change in your coverage will take effect as of the date that the qualified life event occurred.

Important note: If you don't make your changes within **31 days** of the date that a qualified life event occurs, you will have to wait until the next Annual Enrollment period to change your coverage.

Adding or removing a dependent

If you are adding or removing a dependent as a result of a qualified life event, you are required to provide supporting documentation (such as a copy of your marriage certificate, your child's birth certificate, documentation of a legal adoption, copy of your divorce certificate, or proof of lost or new coverage).

Follow the steps listed above in *Changing coverage* to securely upload your documents.

When coverage ends

Coverage under the Ben E. Keith benefit plans described in this Summary Plan Description will end on the earliest of the following dates:

- For life/AD&D coverage, the last day of your employment.
- For medical, dental and vision coverage, the last day of the month in which your employment terminates.
- The date that you become part of a class of employees who are not eligible to participate in the plan(s).
- For your spouse or any of your dependents, the date your spouse or dependent ceases to be an eligible dependent; covered dependent children cease to be covered on the last day of the month in which they turn 26.
- The date on which you fail to make any required contributions toward the cost of your coverage (or the end of any applicable grace period, if later).
- The date on which the Company terminates the plan or insurance policy. If you are rehired within 30 days of termination, you will automatically be re-enrolled in benefits with the same coverage you had prior to termination.

Treatment in progress and other coverage continuation provisions

There may be circumstances (other than COBRA) under which your coverage under a benefit plan may be continued for a limited period after your coverage would otherwise have ended. You may also be allowed to convert certain portions of your supplemental life/AD&D coverage to an individual policy.

Review the appropriate chapter for more information concerning other continuation provisions.

When your coverage ends, you and/or your dependents may be eligible to continue coverage for a specified period of time at your own expense under COBRA. See the *General Notice of COBRA Continuation Rights* in the **Plan administration and ERISA rights** chapter for a description of COBRA benefit continuation.

BEK Medical Plans & prescription drugs

This chapter describes the medical benefits available to you and your covered family members under the Ben E. Keith Company Welfare Benefit Plan. Ben E. Keith employees can choose from two medical plans:

- PPO (the BEK PPO Medical Plan).
- HSA with optional Health Savings Account (the BEK HSA Medical Plan).

For specific information about how Health Savings Accounts (HSAs) work, see the *Health Savings Accounts* section of this chapter. The BEK HSA Medical Plan is intended to qualify as a high deductible health plan (HDHP) under the Internal Revenue Code for the purposes of enabling you to contribute to a health savings account.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for the BEK Medical Plans.

To find:	Go to or call:
An online version of this **BEK Medical Plans & prescription drugs** chapter	bek.family under the **Resources** section, accessible through the menu
Health Savings Account, if enrolled in the BEK HSA Medical Plan	Optum Health at optumbank.com or call 1-844-326-7967
Member services, claim inquiries, personal health support and the mental health/substance abuse administrator	myuhc.com or call 1-844-587-8503
Submit a claim	UnitedHealthcare – Claims United HealthCare Services, Inc. P.O. Box 30555 Salt Lake City, Utah 84130-0555

Eligibility

Participation in the Ben E. Keith Medical Plans is open to eligible employees and their dependents. The eligibility rules for Plan participation can be found in the **Eligibility and enrollment** chapter, which also describes:

- When Plan participation begins.
- Cost of coverage.
- How to enroll.
- Changing your coverage during the year.
- When Plan participation ends.

Note: Coverage for new domestic partners was discontinued effective January 1, 2016. If you enrolled your domestic partner and his or her child(ren) in the Plan prior to January 1, 2016, they may remain covered under the Plan as grandfathered participants. Eligibility for a grandfathered domestic partner and his or her child(ren) will end if the domestic partnership is terminated. The grandfathered child(ren) of a domestic partner will also lose eligibility upon reaching the limiting age of 26 unless disabled as described above. If an employee drops coverage for a domestic partner or child of a domestic partner, they will not be eligible to re-enroll.

In addition to the above eligibility criteria, you or any covered dependent over the age of 18 must have a diabetes-related condition in order to enroll in the Diabetic Health Plan program.

Note: Your dependents may not enroll in the Plan unless you are also enrolled. If you and your spouse are both covered under the Ben E. Keith Company Welfare Benefit Plan, you may each be enrolled as a participant or be

covered as a dependent of the other person, but not both. In addition, if you and your spouse are both covered under the Ben E. Keith Company Welfare Benefit Plan, only one parent may enroll your child as a dependent.

See the **Eligibility and enrollment** chapter for more information.

Cost of coverage

You and Ben E. Keith Company share in the cost of the Plan. Your contribution amount depends on the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld – and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and Ben E. Keith Company reserves the right to change contribution limits from time to time.

You can obtain current contribution rates during your online enrollment by logging on to dayforcehcm.com, then click on “Benefits”, then “Start Enrollment”.

How to enroll

To enroll, log on to dayforcehcm.com, click on “Benefits”, then click “Start Enrollment” and complete your enrollment by the first day of the month following 60 days of employment. If you do not enroll within the aforementioned time frame, you will need to wait until the next Annual Enrollment to make your benefit elections.

During Annual Enrollment, you have the opportunity to review and change your medical election. Any changes made during Annual Enrollment will take effect on January 1st.

You may change your medical plan election if you experience a qualified life event (refer to the *Changing your coverage* section for a list of qualified changes in family status). To make a change to your benefits, go to dayforcehcm.com to add or change your coverage within 31 days of the qualified life event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

Note: You have 60 days to enroll for certain Medicaid or CHIP events. Please see the *Changing your coverage* section of this chapter.

IMPORTANT NOTE:
You will be required to provide documents to verify the eligibility of any dependents covered on the Ben E. Keith Company Welfare Benefit Plan. To enroll your family members in the Ben E. Keith Company Welfare Benefit Plan, you must complete the enrollment process and provide dependent verification documents to prove eligibility. Examples of documentation include birth certificates, marriage certificates, tax returns or court ordered documentation.

When coverage begins

For newly-hired employees who complete an enrollment request, coverage will begin on the first day of the month following 60 days of employment. Coverage for your dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner, and provide verification of dependent eligibility documentation as requested on dayforcehcm.com.

Coverage for a dependent (spouse, child, stepchild, etc.) that you add to the Plan as a result of a qualified life event, becomes effective the date of the event, provided you complete a qualified life event change on dayforcehcm.com within 31 days of the event.

Note: You will have 60 days to submit a qualified life event change on dayforcehcm.com for certain Medicaid or CHIP events. Please see the *Changing your coverage* section of this chapter.

Rehires that have had a break of 30 days or less in employment will be reinstated with no waiting period. For any rehire with a break greater than 30 days, coverage will begin on the first day of the month following 60 days of employment.

If you are hospitalized when your coverage begins
If you are an inpatient in a hospital, skilled nursing facility or inpatient rehabilitation facility on the day your coverage begins, the Plan will pay benefits for covered health services related to that inpatient stay as long as you receive covered health services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network benefits are available only if you receive covered health services from network providers.

Changing your coverage

You may make coverage changes during the year only if you experience a qualified life event. The change in coverage must be consistent with the event (e.g., you cover your spouse following your marriage, your child following an adoption, etc.). See the **Eligibility and enrollment** chapter for more information.

If you wish to change your elections, you must go to dayforcehcm.com and complete a qualified life event request within 31 days of the qualified life event. Otherwise, you will need to wait until the next Annual Enrollment to change coverage.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible dependent if COBRA is elected.

Example of a qualified life event
Jane is married and has two children who qualify as dependents. During Annual Enrollment, she elects not to participate in Ben E. Keith Company's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job. As a result, Tom loses his eligibility for medical coverage. Due to this qualified life event, Jane can elect family medical coverage under Ben E. Keith Company's medical plan outside of the Annual Enrollment period.

How the medical plans work

Accessing network and non-network benefits
As a participant in this Plan, you can choose the physician or health care professional you prefer each time you need to receive covered health services. The choices you make affect the amounts you pay, as well as the level of benefits you receive and any benefit limitations that may apply.

You are eligible for the network level of benefits under this Plan when you receive covered health services from physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive designated network benefits, network benefits or non-network benefits.

Designated network benefits apply to covered health services that are provided by a network physician or other provider that is identified as a designated provider. Only certain physicians and providers have been identified as a designated provider. Designated network benefits are available only for specific covered health services as identified in the *Plan highlights* section of this chapter. When designated network benefits apply, they may be included in and subject to the same annual deductible and out-of-pocket maximum requirements as all other covered health services provided by network providers.

Network benefits apply to covered health services that are provided by a network physician or other network provider. You are not required to select a primary physician in order to obtain network benefits. In general health care terminology, a primary physician may also be referred to as a “Primary care physician” or “PCP.”

Non-network benefits apply to covered health services that are provided by a non-network physician or other non-network provider, or covered health services that are provided at a non-network facility.

Emergency health services provided by a non-network provider will be reimbursed as set forth under *Eligible expenses* later in this section.

Covered health services provided at certain network facilities by a non-network physician, when not emergency health services, will be reimbursed as set forth under *Eligible expenses* as described later in this section. For these covered health services, "certain network facility" is limited to a hospital (as defined in 1861(e) of the Social Security Act), a

hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act*)*, and any other facility specified by the Plan.

Air ambulance transport provided by a non-network provider will be reimbursed as set forth under *Eligible expenses* as described later in this section.

You must show your Medical ID every time you request health care services from a network provider. If you do not show your ID card, network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive covered health services from a network provider, you pay less than you would if you receive the same care from a non-network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a network provider.

If you choose to seek care outside the network, the Plan generally pays at a lower level. You are required to pay the amount that exceeds the eligible expense. The amount in excess of the eligible expense could be significant, and this amount does not apply to the out-of-pocket maximum. You may want to ask the non-network provider about their billed charges before you receive care.

Health services from non-network providers paid as network benefits
If specific covered health services are not available from a network provider, you may be eligible to receive network benefits when covered health services are received from a non- network provider. In this situation, your network physician will notify UnitedHealthcare and if UnitedHealthcare confirms that care is not available from a network provider, UnitedHealthcare will work with you and your network physician to coordinate care through a non-network provider.

Looking for a network provider?
Find a directory of health care professionals and facilities in the UnitedHealthcare network at myuhc.com. While the status of network providers may change from time to time, this site will have the most current network information.

Network providers
UnitedHealthcare or its affiliates arrange for health care providers to participate in a network. At your request, UnitedHealthcare will send you a directory of network providers free of charge. Keep in mind, a provider's network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your Medical ID card or log onto myuhc.com.

Network providers are independent practitioners and are not employees of Ben E. Keith Company or UnitedHealthcare.

UnitedHealthcare’s credentialing process confirms public information about the providers’ licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at myuhc.com or by calling the telephone number on your Medical ID card to request a copy. If you receive a covered health service from a non-network provider and were informed incorrectly prior to receipt of the covered health service that the provider was a network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for network benefits.

It is possible that you might not be able to obtain services from a particular network provider. The network of providers is subject to change. Or you might find that a particular network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another network provider to get network benefits. However, if you are currently receiving treatment for covered health services from a provider whose network status changes from network to non-network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the network benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure

to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, call the telephone number on your Medical ID card.

If you are currently undergoing a course of treatment utilizing a non-network physician or health care facility, you may be eligible to receive transition of care benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care benefits, please contact UnitedHealthcare at the telephone number on your Medical ID card.

Do not assume that a network provider's agreement includes all covered health services. Some network providers contract with UnitedHealthcare to provide only certain covered health services, but not all covered health services. Some network providers choose to be a network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Designated providers
If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a designated provider chosen by UnitedHealthcare. If you require certain complex covered health services for which expertise is limited, UnitedHealthcare may direct you to a network facility or provider that is outside your local geographic area. If you are required to travel to obtain such covered health services from a designated provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare’s discretion.

In both cases, network benefits will only be paid if your covered health services for that condition are provided by or arranged by the designated provider or other provider chosen by UnitedHealthcare.

You or your network physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a designated provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-network facility (regardless of whether it is a designated provider) or other non-network provider, network benefits will not be paid. Non-network benefits may be available if the special needs services you receive are covered health services for which benefits are provided under the Plan.

Possible limitations on provider use
If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of network providers may be limited. If this happens, you may be required to select a single network physician to provide and coordinate all of your future covered health services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a network physician for you. In the event that you do not use the selected network physician, covered health services will be paid as non-network benefits.

Eligible expenses

Ben E. Keith Company has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a covered health service and how the eligible expenses will be determined and otherwise covered under the Plan.

Eligible expenses are the amount the Claims Administrator determines that the Plan will pay for benefits.

- For designated network benefits and network benefits for covered health services provided by a network provider, except for your cost sharing obligations, you are not responsible for any difference between eligible expenses and the amount the provider bills.
- For non-network benefits, except as described below, you are responsible for paying, directly to the non-network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for eligible expenses.
  - For covered health services that are **ancillary services received at certain network facilities on a non-emergency basis from non-network physicians**, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the recognized amount as defined in this SPD.
  - For covered health services that are **non-ancillary services received at certain network facilities on a non-emergency basis from non-network physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which**

notice and consent has been satisfied as described in the following, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.

- For covered health services that are **emergency health services provided by a non-network provider**, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in this SPD.
- For covered health services that are **air ambulance services provided by a non-network provider**, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by a network provider which is based on the recognized amount as defined in this SPD.

Eligible expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated network benefits and network benefits

Eligible expenses are based on the following:

- When covered health services are received from a designated network and network provider, eligible expenses are our contracted fee(s) with that provider.
- When covered health services are received from a non-network provider as arranged by the Claims Administrator, eligible expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-network benefits

When covered health services are received from a non-network provider as described below, eligible expenses are determined as follows:

- For **non-emergency covered health services received at certain network facilities from non-network physicians** when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Plan, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Plan.

  IMPORTANT NOTE: For ancillary services, non-ancillary services provided without notice and consent, and non-ancillary services for unforeseen or urgent medical needs that arise at the time a service you are not responsible, and a non-network physician may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in this SPD.

- **For emergency health services provided by a non-network provider,** the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTICE: You are not responsible, and a non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in this SPD.

- **For air ambulance transportation provided by a non-network provider**, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTE: You are not responsible, and a non-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by a network provider which is based on the recognized amount as defined in the SPD.

When covered health services are received from a non-network provider, except as described above, eligible expenses are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-network provider, the applicable coinsurance, copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible to access the advocacy services as described below. Following the conclusion of the advocacy services described in the following, any responsibility to pay more than the eligible expense (which includes your coinsurance, copayment, and deductible) is yours.

Advocacy services
The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the eligible expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator at the number on your Medical ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if the Claims Administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the eligible expense, and the Claims Administrator, or its designee, determines that it would serve the best interests of the Plan and its Participants (including interests in avoiding costs and expenses of disputes over payment of claims), the Claims Administrator, or its designee, may use its sole discretion to increase the eligible expense for that particular claim.

Don’t forget your Medical ID card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your Medical ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual deductible
The annual deductible is the amount of eligible expenses, or the recognized amount when applicable, you must pay each calendar year for covered health services before you are eligible to begin receiving benefits. There are separate network and non-network annual deductibles for this Plan. The amounts you pay toward your annual deductible accumulate over the course of the calendar year. If a mid-year change is allowed due to a qualifying event which results in a Medical ID number change, you will receive credit for any portion of the deductible satisfied under your previous Medical ID number.

The annual deductible applies to all covered health services under the Plan, including covered health services provided in the *Prescription drugs* section of this chapter.

Eligible expenses charged by both network and non-network providers apply towards both the network individual and family deductibles and the non-network individual and family deductibles.

Any amount you pay for medical expenses in the last three months of the calendar year which were applied to the previous year deductible will also be carried over and applied to the new year deductible. This carry-over feature applies to the individual and family deductible.

Copays (if you enroll in the BEK PPO Medical Plan)
A copayment (copay) is the amount you pay each time you receive certain covered health services. The copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the out-of-pocket-

maximum. Copays do not count toward the annual deductible. If the eligible expense is less than the copay, you are only responsible for paying the eligible expense and not the copay.

Coinsurance
Coinsurance is the percentage of eligible expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain covered health services after you meet the annual deductible.

Example of coinsurance
Let's assume that you receive Plan benefits for outpatient surgery from a network provider. Since the Plan pays 70% after you meet the annual deductible, you are responsible for paying the other 30%. This 30% is your coinsurance.

Out-of-pocket maximum
The annual out-of-pocket maximum is the most you pay each calendar year for covered health services. There are separate network and non-network out-of-pocket maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of eligible expenses for covered health services through the end of the calendar year. If a mid-year change is allowed due to a qualifying event which results in a Member ID number change, you will receive credit for any portion of the out-of-pocket maximum satisfied under your previous ID number.

The out-of-pocket maximum applies to all covered health services under the Plan, including covered health services provided in the *Prescription drugs* section of this chapter.

Eligible expenses charged by both network and non-network providers apply toward both the network individual and family out-of-pocket maximums and the non-network individual and family out-of-pocket maximums.

Any amount you pay for medical expenses in the last three months of the calendar year, will be carried over to the new year and will be applied to the current year out-of-pocket maximum. This carry-over feature applies to the individual and family deductible.

The following chart identifies what does and does not apply toward your network and non-network out-of-pocket maximums:

Plan features	BEK PPO Plan		BEK HSA Plan	
	Applies to the network out-of-pocket maximum?	Applies to the non-network out-of-pocket maximum?	Applies to the network out-of-pocket maximum?	Applies to the non-network out-of-pocket maximum?
Copays, even those for covered health services available in the *Prescription drugs* section of this chapter	Yes	Yes	N/A	N/A
Payments toward the annual deductible	Yes	Yes	Yes	Yes
Inpatient confinement deductible	N/A	Yes	N/A	N/A
Coinsurance payments, even those for covered health services available in the *Prescription drugs* section of this chapter	Yes	Yes	Yes	Yes
Charges for non-covered health services	No	No	No	No
The amounts of any reductions in benefits you incur by not obtaining prior authorization as required	No	No	No	No
Charges that exceed eligible expenses, or the recognized amount when applicable	No	No	No	No

Personal health support

Care management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered dependents.

Personal Health Support nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a personal health support nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The personal health support nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal health support nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the personal health support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the personal health support program includes:

- **Admission counseling** – Personal health support nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your Medical ID card for support.
- **Inpatient care management** – If you are hospitalized, a personal health support nurse will work with your physician to make sure you are getting the care you need and that your physician's treatment plan is being carried out effectively.
- **Readmission management** – This program serves as a bridge between the hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a personal health support nurse to confirm that medications, needed equipment, or follow-up services are in place. The personal health support nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk management** – Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer management** – You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney management** – You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CDK stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a personal health support nurse but feel you could benefit from any of these programs, please call the number on your Medical ID card.

Prior authorization

UnitedHealthcare requires prior authorization for certain covered health services. Network primary physicians and other network providers are responsible for obtaining prior authorization before they provide services to you. There are certain non-network benefits, however, for which you are responsible for obtaining prior authorization. For detailed information on non-network benefits that require prior authorization, please refer the *Additional coverage details* section of this chapter.

It is recommended that you confirm with the Claims Administrator that all covered health services listed in the *Additional coverage details* section of this chapter have been pre-authorized as required. Before receiving these services from a network provider, you may want to contact the Claims Administrator to verify that the hospital,

physician and other providers are network providers and that they have obtained the required prior authorization. Network facilities and network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on your Medical ID card.

When you choose to receive certain covered health services from non-network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-network provider intends to admit you to a network facility or refers you to other network providers.

To obtain prior authorization, call the number on your Medical ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

When you choose to receive certain covered health services from non-network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your non-network benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in the *Additional coverage details* section within each covered health service benefit description in this SPD. Please note that prior authorization timelines apply. Refer to the applicable benefit description to determine how far in advance you must obtain prior authorization.

Special note regarding Medicare
If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in the *Coordination of Benefits (COB)* section of this chapter. You are not required to obtain authorization before receiving covered health services.

Plan highlights

Payment terms and features

Plan features	BEK PPO Plan		BEK HSA Plan	
	Designated network and network	Non-network	Designated network and network	Non-network
Copays[1] • Emergency health services • Physician's office services • Specialist • Urgent care center services • Designated virtual network provider	• $200 • $35 • $50 • $75 • $20	• $200 • Not applicable • Not applicable • Not applicable • Not applicable	N/A	N/A
Annual deductible[2, 5] **individual / family**	$1,000 / $3,000	$2,000 / $6,000	$2,800 / $5,600	$5,600 / $11,200
	Family deductible not to exceed the applicable individual amount for all covered persons in a family		Cumulative annual deductible amount for family	
Per-occurrence deductible[3, 6] Hospital – inpatient stay	N/A	$300	N/A	N/A
Calendar year out-of-pocket maximum individual / family	$3,000 / $6,000	$6,000 / $12,000		
	Family maximum not to exceed the applicable individual amount for all covered persons in a family		Cumulative out-of-pocket maximum for family	
Lifetime maximum benefit[4] There is no dollar limit to the amount the Plan will pay for essential benefits during the entire period you are enrolled in this Plan	Unlimited			

[1]PPO Plan only: In addition to these copays, you may be responsible for meeting the annual deductible for the covered health services described in the chart on the following pages of this chapter. With the exception of emergency health services, a copay does not apply when you visit a non-network provider.

[2]PPO Plan only: Copays do not apply toward the annual deductible. Copays apply to the out-of-pocket maximum. The annual deductible applies toward the out-of-pocket maximum for all covered health services.

[3]This Plan contains a per occurrence deductible that applies to certain covered health services. This per occurrence deductible must be met prior to and in addition to the annual deductible.

[4]Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[5]The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your annual deductible.

[6]The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your annual out-of-pocket maximum.

Schedule of Benefits
This table provides an overview of the Plan's coverage levels. For detailed descriptions of your benefits, refer to the *Additional coverage details* section of this chapter.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on eligible expenses or for specific covered health services, called a “recognized amount,” defined as the amount which copay and/or coinsurance and applicable deductible is based on for covered health services when provided by non-network providers including:

- Non-network emergency health services.
- Non-emergency covered health services received at certain network facilities by non-network physicians, when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Plan.

The amount is based on either:

- An All Payer Model Agreement if adopted;
- State law; or
- The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the recognized amount to determine your cost sharing may be higher or lower than if cost sharing for these covered health services were determined based upon an eligible expense.

IMPORTANT NOTE:
The healthcare service, supply or pharmaceutical product is only a covered health service if it is “medically necessary,” as defined in the **Definitions** chapter. The fact that a physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a sickness, injury, mental illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a covered health service under the Plan.

Covered health services[1]	**BEK PPO Medical Plan** Percentage of eligible expenses paid by the Plan		**BEK HSA Medical Plan** Percentage of eligible expenses paid by the Plan	
	Designated network benefits and network benefits	**Non-network benefits**	**Designated network benefits and network benefits**	**Non-network benefits**
AIDS related conditions (ARC)	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this section			
Ambulance services – emergency only Eligible expenses for air ambulance transport provided by a non-network provider will be determined as described in the *How the Plan works* section of this chapter	*Ground and/or air transportation* 70% after you meet the annual deductible	*Ground and/or air transportation* 70% after you meet the network annual deductible	*Ground and/or air transportation* 70% after you meet the annual deductible	*Ground and/or air transportation* 70% after you meet the network annual deductible

Cellular and gene therapy Services must be received at a designated provider	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this section	Non-network benefits are not available	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this section	Non-network benefits are not available
Clinical trials Benefits are available when the covered health services are provided by either network or non-network providers	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this section			
Congenital Heart Disease (CHD) Surgeries Depending upon where the covered health service is provided, benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each *Covered health service* category in this chart	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Dental services – accident only	70% after you meet the annual deductible		70% after you meet the annual deductible	
Diabetes services – diabetes self-management and training, diabetic eye examinations, foot care	Depending upon where the covered health service is provided, benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each covered health service category in this section			
Diabetes services – self-management items See *Durable medical equipment* in the *Additional coverage details* section of this chapter	Depending upon where the covered health service is provided, benefits for diabetes self-management items will be the same as those stated under *Durable medical equipment* in this section and in the *Prescription drugs* section of this chapter			
Durable medical equipment (DME)	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Emergency health services – outpatient (Copay is per visit) Eligible expenses for emergency health services provided by a non-network provider will be determined as described under *Eligible expenses* in the *How the Plan works* section of this chapter. ***PPO Plan only:*** If you are admitted as an inpatient to a hospital directly from the emergency room, you will not have to pay this copay. The benefits for an inpatient stay in a hospital will apply instead. This	70% after you pay a $200 copay and meet the network annual deductible		70% after you meet the network annual deductible	

does not apply to services provided to stabilize an emergency after admission to a hospital.				
Enteral nutrition	100% after you pay a $50 copay	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Eye examinations See the *Additional coverage details* section of this chapter for limits	100% after you pay a $35 copay 100% for retinal exam with a diabetes-related diagnosis	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Fertility preservation for iatrogenic infertility See the *Additional coverage details* section of this chapter for limits	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Home health care Benefits for home health agency services include private duty nursing See the *Additional coverage details* section of this chapter for limits	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Hospice care	100%		100% after you meet the annual deductible	
Hospital – inpatient stay	70% after you meet the annual deductible	50% after you pay the hospital confinement deductible of $300 and meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Injections received in a physician's office (Copay is per visit) No copayment applies when a physician charge is not assessed	100% after you pay a $35 PCP / $50 specialist copay	50% per injection after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Maternity services A deductible will not apply for a newborn child whose length of stay in the hospital is the same as the mother's length of stay	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this section		Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this section	
Breast pumps	100%	50% after you meet the annual deductible	100%	50% after you meet the annual deductible
Mental health services				
Inpatient	70% after you meet the annual deductible	50% after you pay the hospital confinement deductible of $300 and meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible

Physician's office services (copay is per visit)	100% after you pay a $35 copay	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after meet the annual deductible
Virtual behavioral health therapy and coaching	AbleTo Therapy 360: 100%	Non-network benefits not available	AbleTo Therapy 360: 100% after you meet the annual deductible; benefits for the initial consultation will be paid at 100%	Non-network benefits not available
Neurobiological disorders – autism spectrum disorder services				
Inpatient	70% after you meet the annual deductible	50% after you pay the hospital confinement deductible of $300 and meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Outpatient (copay is per visit)	100% after you pay a $35 copay	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Orthognathic surgery	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this section			
Ostomy supplies	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Outpatient surgery, diagnostic and therapeutic services				
Outpatient surgery	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Outpatient diagnostic services				
Preventive lab and radiology/X-ray	100%	50% after you meet the annual deductible	100%	50% after you meet the annual deductible
Preventive or diagnostic mammography testing	100%	50% after you meet the annual deductible	100%	50% after you meet the annual deductible
Preventive or diagnostic colonoscopy	100%	50% after you meet the annual deductible	100%	50% after you meet the annual deductible
Sickness and injury related diagnostic services	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
HbA1c, LDL cholesterol and preventive cancer screenings with a diabetes-related condition diagnosis	100%	50% after you meet the annual deductible	100%	50% after you meet the annual deductible

Outpatient diagnostic/therapeutic services – CT scans, PET scans, MRI and nuclear medicine	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Outpatient therapeutic treatments	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Dialysis	80% after you meet the annual deductible	Not covered	80% after you meet the annual deductible	Not covered
Pharmaceutical products – outpatient	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Physician fees for surgical and medical services Covered health services provided by a non-network physician in certain network facilities will apply the same cost sharing (copayment, coinsurance and applicable deductible) as if those services were provided by a network provider; however eligible expenses will be determined as described under *Eligible expenses* in the *How the Plan works* section of this chapter	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
PPO Plan physician's office services – No copay applies when a physician charge is not assessed				
Primary physician	100% after you pay a $35 copayment per visit	50% after you meet the annual deductible	N/A	
Specialist physician	100% after you pay a $50 copayment per visit	50% after you meet the annual deductible		
Diabetes-related condition diagnosis	100%	50% after you meet the annual deductible		
Home visits	70% after you meet the annual deductible	50% after you meet the annual deductible		
HSA Plan physician's office services				
Diabetes-related condition diagnosis	N/A		100%	50% after you meet the annual deductible
All other services			70% after you meet the annual deductible	50% after you meet the annual deductible
Preimplantation genetic testing (PGT) and related services See the *Additional coverage details* section of this chapter for limits	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible

Preventive care services				
Physician office services	100%	50% after you meet the annual deductible	100%	50% after you meet the annual deductible
Outpatient diagnostic services	100%	50% after you meet the annual deductible	100%	50% after you meet the annual deductible
Private duty nursing – outpatient	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Prosthetic devices	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Reconstructive procedures	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service category in this section			
Rehabilitation and habilitative services – outpatient therapy	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Skilled nursing facility/inpatient rehabilitation facility services See the *Additional coverage details* section of this chapter for limits	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Spinal treatment See the *Additional coverage details* section of this chapter for limits	100% after you pay a $50 copayment per visit	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Substance use disorder services				
Inpatient	70% after you meet the annual deductible	50% after you pay the hospital confinement deductible of $300 and meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Outpatient (copay is per visit)	100% after you pay a $35 copay	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Temporomandibular joint dysfunction (TMJ)	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible

Transplantation services Covered health services must be received at a designated provider	Depending upon where the covered health services is provided, benefits for transplantation services will be the same as those stated under each covered health services category in this section.	Non-network benefits are not covered by the Plan	Depending upon where the covered health services is provided, benefits for transplantation services will be the same as those stated under each covered health services category in this section.	Non-network benefits are not covered by the Plan
Urgent care center services (copay is per visit)	100% after you pay a $75 copay	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible
Virtual care services Benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by contacting UnitedHealthcare at myuhc.com or by calling the number on your Medical ID card.	100% after you pay a $20 copay	Non-network benefits are not available	70% after you meet the annual deductible	Non-network benefits are not covered by the Plan
Wigs	70% after you meet the annual deductible	50% after you meet the annual deductible	70% after you meet the annual deductible	50% after you meet the annual deductible

[1]You must obtain prior authorization, as described in the *Personal health support* section of this chapter to receive full benefits before receiving certain covered health services from a non-network provider. See the *Additional coverage details* section of this chapter for further information on your prior authorization requirements for non-network benefits. If you visit a network provider, that provider is responsible for obtaining prior authorization before you receive certain covered health services.

Enhanced benefits

In addition to the benefits listed above, Ben E. Keith Company, through UnitedHealthcare, also offers a way for individuals and their eligible and enrolled dependents who have been diagnosed with a diabetes-related condition to receive a reduction or waiver of copayments or coinsurance with respect to certain benefits. In order to receive these enhanced benefits, you must meet all of the requirements identified. Your participation is completely voluntary; however, if you do not meet all of the following criteria, your benefits will be paid at the levels described in the previous *Schedule of Benefits* and under *Pharmaceutical products – outpatient* in the *Additional coverage details* section of this chapter*,* and you will not be eligible for these enhanced benefits in the following Plan year. Any benefits not specifically identified in the following will be paid as identified earlier in this section and under *Pharmaceutical products – outpatient* in the *Additional coverage details* section of this chapter.

Your compliance with regard to the participation criteria outlined in the following will be monitored on an ongoing basis to ensure compliance and eligibility. At the end of each calendar year, if you have not met the criteria for that year, you may not be eligible for the enhanced diabetic-related benefits the following calendar year

Members with diabetes-related conditions who meet the following criteria are eligible for enhanced benefits:

- Be at least 18 years old;
- Visit your physician between two and four times each calendar year;
- Receive the following tests and exams:
  - Hemoglobin A1C check (members with diabetes only) between two and four times each calendar year;
  - LDL cholesterol check once every calendar year;
  - Creatinine or microalbuminuria (members with diabetes only) check once every calendar year; and
  - Retinal eye exam (members with diabetes only) once every calendar year.

- Colon screening (age 50 or older) as follows:
  - Colonoscopy once every ten years, or
  - Sigmoidoscopy once every five years, or
  - Fecal occult blood test once every year.
- Mammogram (females age 40 or older) once every two calendar years;
- PSA test (males age 40 or older) discussed annually with your physician but as recommended by your physician;
- Enroll and participate in at least one online wellness program available through myuhc.com; and
- Enroll and participate in the disease management program most appropriate for you (when asked to participate by UnitedHealthcare).

Health Savings Account

An HSA is a tax-advantaged account participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- Accumulate over time with interest or investment earnings.
- Are portable after employment.
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Ben E. Keith Company has entered into an agreement with United Healthcare Services, Inc., Minnetonka, MN, ("UnitedHealthcare" or “UHC”) under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this SPD. Further, note that it is the Plan's intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described is not an arrangement that is established and maintained by Ben E. Keith Company. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

The HSA can help you to cover, on a tax-free basis, medical plan expenses that require you to pay out-of-pocket, such as deductibles or coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses; however, these amounts are subject to income tax and may be subject to 20% penalty.

BEK HSA Medical Plan eligibility

You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you must:

- Not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- Not participate in a health care Flexible Spending Account (FSA).
- Not be entitled to benefits under Medicare (i.e., enrolled in Medicare). check
- Not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximums are the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at irs.gov.

If you enroll in your HSA during the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

Reimbursable expenses
The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including annual deductibles and coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". See the description in the following *Additional medical expense coverage available with your Health Savings Account* section for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

Additional medical expense coverage available with your Health Savings Account
A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not covered health services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your annual deductible or out-of-pocket maximum.

Using the HSA for non-qualified expenses
You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Rollover feature
If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage in the high deductible health plan.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, your HSA funds can be used to pay out-of-pocket costs under the medical plan and any COBRA premiums while your COBRA coverage is in effect.

IMPORTANT NOTE:
Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Ben E. Keith Company and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Ben E. Keith Company and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

Additional information about the HSA
It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA online at irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a dependent's intent to open an HSA.

Additional coverage details

This section supplements the *Schedule of Benefits* in the *Plan highlights* section of this chapter and will indicate how your benefits may be affected if you do not obtain prior authorization for certain non-network benefits. While the *Schedule of Benefits* provides you with benefit limitations along with copayment, coinsurance and annual deductible information for each covered health service, this section includes descriptions of the benefits. These descriptions include any additional limitations that may apply, as well as covered health services for which you must call personal health support. The covered health services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in the *Exclusions: what the medical Plan will not cover* section of this chapter.

Benefits are provided for services delivered via telehealth/telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section unless otherwise specified under *Virtual care services* in the *Schedule of Benefits*.

AIDS related conditions (ARC)
The Plan will pay benefits for all treatments related to Acquired Immune Deficiency Syndrome (AIDS) and any other AIDS related conditions.

Ambulance services – emergency only
Emergency ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be performed.

Cellular and gene therapy
Cellular therapy and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation services* later in this chapter.

Clinical trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below;
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below; and
- Other diseases or disorders for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the covered person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered health services for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The experimental or investigational service or item. The only exceptions to this are:
  - Certain Category B devices;
  - Certain promising interventions for patients with terminal illnesses; and
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies.

  Experimental or investigational services are defined as medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:
  - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
  - Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be experimental or investigational); or
  - The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

  Exceptions:
  - Clinical trials for which benefits are available as described under *Clinical trials* in the *Additional coverage details* section of this chapter.
  - If you are not a participant in a qualifying clinical trial as described the *Additional coverage details* section and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). Includes National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

For non-network benefits you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Congenital heart disease (CHD) surgeries

The Plan pays benefits for congenital heart disease (CHD) services ordered by a physician and received at a CHD resource services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- Outpatient diagnostic testing;
- Evaluation;
- Surgical interventions;
- Interventional cardiac catheterizations (insertion of a tubular device in the heart);
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and

- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is available at myoptumhealthcomplexmedical.com.

If you receive congenital heart disease services from a facility that is not a designated provider, the Plan pays benefits as described under the following sections:

- *Physician's office services – sickness and injury;*
- *Physician fees for surgical and medical services;*
- *Outpatient surgery, diagnostic and therapeutic services;*
- *Outpatient therapeutic treatments;*
- *Hospital – inpatient stay; and*
- *Outpatient surgery.*

Prior authorization requirement
For non-network benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Dental services – accident only
Dental services when all of the following are true:

- Treatment is necessary because of accidental damage;
- Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."; and
- The dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth; or
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident, or if not a covered person at the time of the accident, within the first three months of coverage under the Plan; and
- Completed within 12 months of the accident, or if not a covered person at the time of the accident, within the first 12 months of coverage under the Plan.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident." Benefits are not available for repairs to teeth that are injured as a result of such activities.

Diabetes services

The Plan pays benefits for the covered health services identified below.

Covered diabetes services	
Diabetes self-management and training/ diabetic eye examinations/foot care	Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a physician and provided by appropriately licensed or registered health care professionals. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.
Diabetic self-management items	Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable medical equipment (DME)* in this section. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in the *Prescription drugs* section of this chapter.

Prior authorization requirement

For non-network benefits you must obtain prior authorization before obtaining any durable medical equipment for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Durable medical equipment (DME)

The Plan pays for durable medical equipment (DME) that meets each of the following:

- Ordered or provided by a physician for outpatient use;
- Used for medical purposes;
- Not consumable or disposable; and
- Not of use to a person in the absence of a disease or disability.

If more than one piece of DME can meet your functional needs, benefits are available only for the most cost-effective piece of equipment.

Examples of DME include but are not limited to:

- Equipment to assist mobility, such as a standard wheelchair;
- A standard hospital-type bed;
- Oxygen concentrator units and the rental of equipment to administer oxygen;
- Delivery pumps for tube feedings;
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered durable medical equipment and are a covered health service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage;
- Orthopedic shoes and foot orthotics only when there is a diabetes-related diagnosis;
- Casts, splints, crutches and trusses when deemed medically necessary by the Plan and prescribed by a physician;
- Cranial orthotics when deemed medically necessary by the Plan, custom molded and prescribed by a physician. Cranial bands are limited to one band per child per lifetime. Replacement of a cranial orthotic device is not covered if it becomes unusable or nonfunctioning because of misuse, abuse or neglect; and
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with durable medical equipment (DME).

UnitedHealthcare provides benefits only for a single purchase (including repair/ replacement) of a type of durable medical equipment when the Plan considers them medically necessary.

Prior authorization requirement
For non-network benefits you must obtain prior authorization before obtaining any durable medical equipment (DME) or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Emergency health services – outpatient
The Plan pays for services that are required to stabilize or initiate treatment in an emergency. Emergency health services must be received on an outpatient basis at a hospital or alternate facility.

Network benefits will be paid for an emergency admission to a non-network hospital as long as the Claims Administrator is notified within one business day of the admission or as soon as reasonably possible after you are admitted to a non-network hospital. If you continue your stay in a non-network hospital after the date your physician determines that it is medically appropriate to transfer you to a network hospital, non-network benefits will apply.

IMPORTANT NOTE: If you are confined in a non-network hospital after you receive outpatient emergency health services, you must notify the Claims Administrator within one business day or as soon as reasonably possible. If you fail to obtain prior authorization as required, benefits will be subject to a $500 reduction for the inpatient stay in a hospital.

The Claims Administrator may elect to transfer you to a network hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-network hospital after the date the Claims Administrator decides a transfer is medically appropriate, network benefits will not be provided. Non-network benefits may be available if the continued stay is determined to be a covered health service.

Enteral nutrition
Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease;
- Severe food allergies; and
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a physician issues a prescription or written order stating the formula or product is medically necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a physician or registered dietitian.

For the purpose of this benefit, "enteral formulas" include:

- Amino acid-based elemental formulas;
- Extensively hydrolyzed protein formulas; and
- Modified nutrient content formulas.

For the purpose of this benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

Eye examinations
The Plan pays benefits for eye examinations received from a health care provider in the provider's office.

Please note that benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses and refractions.

Fertility preservation for iatrogenic infertility
Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a physician:

- Collection of sperm;
- Cryo-preservation of sperm;
- Ovarian stimulation, retrieval of eggs and fertilization;
- Oocyte cryo-preservation; and
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under the *Prescription drugs* section of this chapter or under *Pharmaceutical products – outpatient* in this section.

Benefits are not available for embryo transfer.

Benefits are not available for long-term embryo storage costs (greater than one year).

Limited to $20,000 per covered person during the entire period of time he or she is enrolled for coverage under the Plan. This benefit limit will be the same as and combined with those stated under *Preimplantation genetic testing (PGT-M and PGT-SR) and related services* in this section. Benefits are further limited to one cycle of fertility preservation for iatrogenic infertility per covered person during the entire period of time he or she is enrolled for coverage under the Plan.

Home health care
Covered health services are services received from a home health agency that are both of the following:

- Ordered by a physician; and
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the home health agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- It is ordered by a physician;
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively; and
- It is not custodial care.

Any combination of network benefits and non-network benefits is limited to 60 visits per calendar year. One visit equals four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Prior authorization requirement
For non-network benefits you must obtain prior authorization five business days before receiving services, including nutritional foods and private duty nursing, or as soon as is reasonably possible. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Hospice care
The Plan pays benefits for hospice care that is recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

Prior authorization requirement
For non-network benefits you must obtain prior authorization five business days before admission for an inpatient stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

In addition, for non-network benefits, you must contact the Claims Administrator within 24 hours of admission for an inpatient stay in a hospice facility.

Hospital – inpatient stay
Hospital benefits are available for:

- Non-physician services and supplies received during the inpatient stay; and
- Room and board in a semi-private room (a room with two or more beds).

Benefits for other hospital-based physician services are described in this section under *Physician fees for surgical and medical services*.

Benefits for emergency admissions and admissions of less than 24 hours are described under *Emergency health services* and *Outpatient surgery, diagnostic and therapeutic services*, respectively.

Prior authorization requirement
For non-network benefits for a scheduled admission, you must obtain prior authorization five business days before an admission, or as soon as reasonably possible for a non-scheduled admission (including an emergency admission). If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

In addition, for non-network benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including emergency admissions).

Injections received in a physician's office
The Plan pays for benefits for injections received in a physician's office when no other health service is received, for example allergy immunotherapy.

Maternity services
Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

There is a special prenatal program to help during pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay benefits for an inpatient stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; and
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. These benefits are described under in the *Plan highlights* section under *Covered health services*.

If more than one breast pump can meet your needs, benefits are available only for the most cost-effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental; and

- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or physician.

Prior authorization requirement
For non-network benefits you must obtain prior authorization as soon as reasonably possible if the inpatient stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Mental health services
Mental health services include those received on an inpatient or outpatient basis in a hospital and an alternate facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:
- Inpatient treatment;
- Residential treatment;
- Partial hospitalization/day treatment;
- Intensive outpatient treatment; and
- Outpatient treatment.

Inpatient treatment and residential treatment levels of care include room and board in a semi-private room (a room with two or more beds).

Services include the following:
- Diagnostic evaluations, assessment and treatment planning;
- Treatment and/or procedures;
- Medication management and other associated treatments;
- Individual, family and group therapy;
- Provider-based case management services; and
- Crisis intervention.

The Mental Health/Substance Use Disorder Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Prior authorization requirement
For non-network benefits for a scheduled admission for mental health services (including an admission for services at a residential treatment facility), you must obtain prior authorization five business days before an admission or as soon as is reasonably possible for a non-scheduled admission (including an emergency admission).

In addition, for non-network benefits you must obtain prior authorization before the following services are received: partial hospitalization/day treatment; intensive outpatient treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Virtual behavioral health therapy and coaching
Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo Therapy 360") for covered persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy 360 provides behavioral covered health care services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Under the BEK PPO Medical Plan, there are no deductibles, copayments or coinsurance you must meet or pay for when receiving these services.

Under the BEK HSA Medical Plan, except for the initial consultation, covered persons with a high deductible health plan (HDHP) must meet their annual deductible before they are able to receive benefits for these services. There are no deductibles, copayments or coinsurance for the initial consultation.

If you would like information regarding these services, contact the Claims Administrator at the telephone number on your Medical ID Card.

Neurobiological disorders – autism spectrum disorder services
The Plan pays benefits for behavioral services for autism spectrum disorder including intensive behavioral therapies such as Applied Behavior Analysis (ABA*)* that are the following:

- Focused on the treatment of core deficits of autism spectrum disorder;
- Provided by a Board-certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These benefits describe only the behavioral component of treatment for autism spectrum disorder. Medical treatment of autism spectrum disorder is a covered health service for which benefits are available under the applicable medical covered health services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment;
- Residential treatment;
- Partial hospitalization/day treatment;
- Intensive outpatient treatment; and
- Outpatient treatment.

Inpatient treatment and residential treatment levels of care include room and board in a semi-private room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning;
- Treatment and/or procedures;
- Medication management and other associated treatments;
- Individual, family and group therapy;
- Provider-based case management services; and
- Crisis intervention.

The Mental Health/Substance Use Disorder Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Prior authorization requirement
For non-network benefits for a scheduled admission for neurobiological disorders – autism spectrum disorder services (including an admission for services at a residential treatment facility), you must obtain prior authorization five business days before an admission or as soon as is reasonably possible for a non-scheduled admission (including an emergency admission).

In addition, for non-network benefits you must obtain prior authorization before the following services are received: partial hospitalization/day treatment; intensive outpatient treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; and intensive behavioral therapy, including Applied Behavior Analysis (ABA).

If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Orthognathic surgery
Benefits for orthognathic surgery are covered for the following situation:

- A skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
  - Inability to incise solid foods;
  - Choking on incompletely masticated solid foods;
  - Damage to soft tissue during mastication;
  - Speech impediment determined to be due to the jaw deformity; or
  - Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.

Ostomy supplies
Benefits for ostomy supplies are limited to:

- Pouches, wafers, face plates and belts;
- Irrigation sleeves, bags and catheters; and
- Skin barriers.

Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.

Outpatient surgery, diagnostic and therapeutic services

Outpatient surgery
The Plan pays for covered health services for surgery and related services received on an outpatient basis at a hospital or alternate facility. If you enroll in the BEK HSA Medical Plan, these services can be also be provided in a physician’s office.

Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees and facility-based physician's fees related to outpatient surgery are described under *Physician fees for surgical and medical services*.

Prior authorization requirement
For non-network benefits for sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Outpatient diagnostic services
The Plan pays for covered health services received on an outpatient basis at a hospital or alternate facility. If you enroll in the BEK HSA Medical Plan, these services can also be provided in a physician’s office. Outpatient diagnostic services include:

- Lab and radiology/X-ray; and
- Mammography testing.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment. Benefits for facility-based physician's fees related to these services are described under *Physician fees for surgical and medical services*.

Benefits under this section also include genetic testing ordered by a physician which results in available medical treatment options following genetic counseling.

Presumptive drug tests and definitive drug tests are covered by the Plan.

Any combination of network benefits and non-network benefits is limited to 18 presumptive drug tests per calendar year.

Any combination of network benefits and non-network benefits is limited to 18 definitive drug tests per calendar year.

This section does not include benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described in the next paragraph.

Prior authorization requirement
For non-network benefits for genetic testing and sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Outpatient diagnostic/therapeutic services – CT scans, PET scans, MRI and nuclear medicine
The Plan pays for covered health services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a hospital or alternate facility. If you enroll in the BEK HSA Medical Plan, these services can also be provided in a physician's office.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment. Benefits for facility-based physician's fees related to these services are described under *Physician fees for surgical and medical services*.

Outpatient therapeutic treatments
The Plan pays for covered health services for therapeutic treatments received on an outpatient basis at a hospital, alternate facility or in a physician's office including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed previously.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment. Benefits for facility-based Physician's fees related to these services are described under *Physician fees for surgical and medical services*.

Coverage for dialysis is limited to network-only benefits.

Prior authorization requirement
For non-network benefits for the following outpatient therapeutic services, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Pharmaceutical products – outpatient
The Plan pays for pharmaceutical products that are administered on an outpatient basis in a hospital, alternate facility, physician's office, or in a covered person's home. Examples of what would be included under this category are antibiotic injections in the physician's office or inhaled medication in an urgent care center for treatment of an asthma attack.

Benefits under this section are provided only for pharmaceutical products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the pharmaceutical product is administered, benefits will be provided for administration of the pharmaceutical product under the corresponding benefit category in this chapter.

If you require certain pharmaceutical products, including specialty pharmaceutical products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those pharmaceutical products. Such dispensing entities may include an outpatient pharmacy, specialty pharmacy, home health agency provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your pharmaceutical product from a designated dispensing entity, network benefits are not available for that pharmaceutical product.

Certain pharmaceutical products are subject to step therapy requirements. This means that in order to receive benefits for such pharmaceutical products, you must use a different pharmaceutical product and/or prescription drug product first. You may find out whether a particular pharmaceutical product is subject to step therapy requirements by contacting UnitedHealthcare at myuhc.com or by calling the number on your Medical ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs online at myuhc.com or by calling the number on your Medical ID card.

Physician fees for surgical and medical services
The Plan pays for physician fees for surgical procedures and other medical care received in a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility or physician house calls.

When these services are performed in a physician's office, benefits are described under the following *Physician's office services – sickness and injury*.

Physician's office services – sickness and injury
Benefits are paid by the Plan for covered health services received in a physician's office for the evaluation and treatment of a sickness or injury. Benefits are provided under this section regardless of whether the physician's office is free-standing, located in a clinic or located in a hospital. Benefits under this section include allergy injections and hearing exams in case of injury or sickness.

Benefits for preventive services are described under *Preventive care services* in this section.

IMPORTANT NOTE: Your physician does not have a copy of your SPD and is not responsible for knowing or communicating your benefits.

Preimplantation genetic testing (PGT-M and PGT-SR) and related services
Preimplantation genetic testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for benefits the following must be met:

- PGT must be ordered by a physician after genetic counseling;
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR); and
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a physician:
  - Ovulation induction (or controlled ovarian stimulation);
  - Egg retrieval, fertilization and embryo culture;
  - Embryo biopsy;
  - Embryo transfer; and
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

Limited to $20,000 per covered person during the entire period of time he or she is enrolled for coverage under the Plan. This limit includes benefits for related services as described under *Fertility preservation for iatrogenic infertility*.

Preventive care services
The Plan pays benefits for preventive care services provided on an outpatient basis at a physician's office, an alternate facility or a hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

In addition to the services listed above, this preventive care benefit includes certain:

- Routine lab tests;
- Diagnostic consults to prevent disease and detect abnormalities;
- Diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- Breast cancer screening and genetic testing; and
- Tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on your Medical ID card for additional information regarding coverage available for specific services.

For questions about your preventive care benefits under this Plan, call the number on your Medical ID card.

Private duty nursing – outpatient
The Plan covers private duty nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Prosthetic Devices
External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands;
- Artificial eyes, ears and noses; and
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years. Benefits are provided for adjustments, repair, and replacements of covered prosthetic devices, special appliances and surgical implants when required due to wear or a change in the covered person’s condition.

The Plan pays benefits for the initial post-mastectomy holding bra. It will not pay benefits for any other post-mastectomy holding bras after the initial one.

Dental appliances are not covered by the Plan.

Note: Prosthetic devices are different from DME - see *Durable medical equipment (DME)* in this section.

Prior authorization requirement
For non-network benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, benefits will be subject to a $500 reduction.

Reconstructive procedures
Reconstructive procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or congenital anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a cosmetic procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Please note that benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health

and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any covered health service. You can contact UnitedHealthcare at the number on your Medical ID card for more information about benefits for mastectomy-related services.

Prior authorization requirement
For non-network benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

In addition, for non-network benefits, you must provide notification to the Claims Administrator 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including emergency admissions).

Rehabilitation and habilitative services – outpatient therapy
The Plan provides short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy (including cognitive rehabilitation therapy following a post- traumatic brain injury or stroke).
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

For all rehabilitation services, a licensed therapy provider, under the direction of a physician (when required by state law), must perform the services.

Benefits under this section include rehabilitation services provided in a physician's office or on an outpatient basis at a hospital or alternate facility. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Rehabilitative services provided in a covered person’s home by a home health agency are provided as described under home health care. Rehabilitative services provided in a covered person’s home other than by a home health agency are provided as described under this section.

Habilitative services
For the purpose of this benefit, "habilitative services" means medically necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is medically necessary to maintain a covered person's current condition or to prevent or slow further decline.
- It is ordered by a physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not custodial care.

The Claims Administrator will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for covered persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or physician.
- The initial or continued treatment must be proven and not experimental or investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial care, respite care, day care, therapeutic

recreation, vocational training and residential treatment are not habilitative services. A service that does not help the covered person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the covered person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for durable medical equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable medical equipment* and *Prosthetic devices* in this section.

Note: Other than as described under habilitative services above, the Plan will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer or congenital anomaly. The Plan will pay benefits for cognitive rehabilitation therapy only when medically necessary following a post-traumatic brain injury or stroke.

Skilled nursing facility/inpatient rehabilitation facility services
The Plan pays for covered health services for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility. Benefits are available for:

- Services and supplies received during the inpatient stay; and
- Room and board in a semi-private room (a room with two or more beds).

Any combination of network benefits and non-network benefits is limited to 60 days per calendar year.

Please note that benefits are available only for the care and treatment of an injury or sickness that would have otherwise required an inpatient stay in a hospital.

Prior authorization requirement
For non-network benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

In addition, for non-network benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including emergency admissions).

Spinal treatment
Benefits for spinal treatment when provided by a spinal treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Benefits may be denied or shortened for covered persons who are not progressing in goal-directed spinal treatment or if the treatment goals have previously been met. Benefits under this section are not available for maintenance and/or preventive spinal treatment.

Any combination of network and non-network benefits for spinal treatment is limited to 20 visits per calendar year.

Substance use disorder services
Substance use disorder services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a hospital, an alternate facility, or in a provider’s office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment;
- Residential treatment;
- Partial hospitalization/day treatment;
- Intensive outpatient treatment; and
- Outpatient treatment.

Inpatient treatment and residential treatment levels of care include room and board in a semi-private room (a room with two or more beds).

Services include the following:
- Diagnostic evaluations, assessment and treatment planning;
- Treatment and/or procedures;
- Medication management and other associated treatments;
- Individual, family and group therapy;
- Provider-based case management services; and
- Crisis intervention.

The Mental Health/Substance Use Disorder Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Prior authorization requirement
For non-network benefits for a scheduled admission for substance use disorder services (including an admission for services at a residential treatment facility), you must obtain prior authorization five business days before an admission or as soon as is reasonably possible for a non-scheduled admission (including an emergency admission).

In addition, for non-network benefits you must obtain prior authorization before the following services are received: partial hospitalization/day treatment; intensive outpatient treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management.

If you do not obtain prior authorization as required, benefits will be subject to a $500 reduction.

Temporomandibular joint (TMJ) services
The Plan pays for covered health services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology.

Benefits are not available for charges or services that are dental in nature.

Transplantation services
Covered health services are covered by the Plan for organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a physician. For network benefits, transplantation services must be received at a designated provider. Benefits are available when the transplant meets the definition of a covered health service, and is not an experimental, investigational or unproven service.

The services described under *Travel and lodging assistance program* in the *Clinical programs and resources* section of this chapter are covered health services **ONLY** in connection with a transplant received at a designated provider.

Examples of transplants for which benefits are available include but are not limited to:
- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a covered health service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a covered health service only for a transplant received at a designated provider;
- CAR-T cell therapy for malignancies;
- Heart transplants;
- Heart/lung transplants;
- Lung transplants;
- Kidney transplants;
- Kidney/pancreas transplants;
- Liver transplants;
- Liver/small bowel transplants;

- Pancreas transplants; and
- Small bowel transplants.

Benefits for cornea transplants that are provided by a network physician at a network hospital are paid as if the transplant was received at a designated provider. Corneal transplants are not required to be performed at a designated provider in order for you to receive network benefits. Donor costs that are directly related to organ removal are covered health services for which benefits are payable through the organ recipient's coverage under the Plan.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding benefits for transplant services. Contact the Claims Administrator at the telephone number on your Medical ID card for information about these guidelines.

Urgent care center services
The Plan pays for covered health services received at an urgent care center. When services to treat urgent health care needs are provided in a physician's office, benefits are available as described under *Physician's office services – sickness and injury* earlier in this section.

Virtual care services
Virtual care for covered health services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by contacting the Claims Administrator at myuhc.com or the number on your Medical ID card.

Benefits are available for the following:
- Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please note: Not all medical conditions can be treated through virtual care. The designated virtual network provider will identify any condition for which treatment by in-person physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (CMS defined originating facilities).

Wigs
The Plan pays benefits for wigs and other scalp hair prosthesis when temporary loss of hair results from the treatment of a malignancy.

Clinical programs and resources

Ben E. Keith Company has made available several convenient educational and support services, accessible by phone and online, which can help you to:
- Take care of yourself and your family members;
- Manage a chronic health condition; and
- Navigate the complexities of the health care system.

IMPORTANT NOTE: Information obtained through the services identified in this section is based on current medical literature and on physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Ben E. Keith Company are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer solutions and self-service tools

Health actions portal – diabetes health plan

This Plan includes access to an online portal available specifically for members enrolled in the diabetes health plan for monitoring your progress toward meeting all the participation criteria described in the *Plan highlights* section and the *Outpatient prescription drugs* section of this chapter required to maintain eligibility in the Plan. You're encouraged to visit the site frequently to keep abreast of the activities you should be completing to help manage your diabetes or pre-diabetes condition and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for diabetes self-care and prevention.

Health survey

You are invited to learn more about your health and wellness at myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your benefits or eligibility for benefits in any way.

If you need any assistance with the online survey, call the number on your Medical ID card.

Reminder programs

To help you stay healthy, UnitedHealthcare may send you and your covered dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women;
- Pediatric and adolescent immunizations;
- Cervical cancer screenings for women;
- Comprehensive screenings for individuals with diabetes; and
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access health care information;
- Support by a nurse to help you make more informed decisions in your treatment and care;
- Expectations of treatment; and
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain;
- Knee & hip replacement;
- Prostate disease;
- Prostate cancer;
- Benign uterine conditions;
- Breast cancer; and
- Coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your Medical ID card.

myuhc.com

Go to myuhc.com to register by clicking on "Register Now." On myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your physician.

- Search for network providers available in your Plan through the online provider directory.
- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures.
- Research conditions and treatments including what the symptoms are, how it is diagnosed, and what to ask your doctor.
- Make real-time inquiries into the status and history of your claims.
- View eligibility and plan benefit information, including copays, coinsurance and annual deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement Medical ID card or, print a temporary ID card.

Health management Virtual Behavioral Health Therapy and Coaching programs

The Virtual Behavioral Health Therapy and Coaching program identifies covered persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for covered persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for behavioral health.

The program is provided through AbleTo, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on your Medical ID card.

Disease management services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, asthma, diabetes, and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your Medical ID card.

Complex medical conditions programs and services

Cancer Resource Services (CRS) program

Your Plan offers the Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit myoptumhealthcomplexmedical.com or call the number on your Medical ID card or the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital heart disease (CHD) resource services

UnitedHealthcare provides a program that identifies and supports a covered person who has congenital heart disease (CHD) through all stages of treatment and recovery. This program will work with you and your physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD nurses, support from specialized social workers, assistance with choosing physicians and facilities, and access to designated providers.

To learn more about the CHD Resource Services program, visit myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your Medical ID card or the CHD Resource Services Nurse Team at 1-888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a covered health service under the Plan.

Comprehensive Kidney Solution (CKS) program

For Participants diagnosed with kidney disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced chronic kidney disease (CKD) through end-stage renal disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top- performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit myoptumhealthcomplexmedical.com or call the number on your Medical ID card.

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS with your decision.

Kidney Resource Services (KRS) program

End-stage renal disease (ESRD). The Kidney Resource Services program provides covered persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Transplant Resource Services (TRS) program

Your Plan offers the Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit myoptumhealthcomplexmedical.com or call the number on your Medical ID card.

Coverage for transplant and transplant-related services are based on your health Plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Travel and Lodging Assistance Program

Your Plan Sponsor may provide you with travel and lodging assistance. Travel and lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a designated provider and the distance from your home address to the facility. Eligible expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, call the Travel and Lodging office at 1-800-842-0843.

Travel and lodging expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a designated provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- The eligible expenses for lodging for the patient (while not a hospital inpatient) and one companion;
- If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered;
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the designated provider;
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate; and
- The transplant program offers an overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

- Lodging
  - A per diem rate, up to $50.00 per day, for the patient (when not in the hospital) or the caregiver;
  - Per diem is limited to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child;
  - Examples of items that are not covered:
    - Groceries.
    - Alcoholic beverages.
    - Personal or cleaning supplies.
    - Meals.
    - Over-the-counter dressings or medical supplies.
    - Deposits.
    - Utilities and furniture rental, when billed separate from the rent payment.
    - Phone calls, newspapers, or movie rentals.

- Transportation
  - Automobile mileage (reimbursed at the current IRS medical rate) for the most direct route between the patient's home and the designated provider.
  - Taxi fares (not including limos or car services).
  - Economy or coach airfare.
  - Parking.
  - Trains.
  - Boat.
  - Bus.
  - Tolls.

Women’s health/reproductive

Maternity support program
If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your Medical ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:
- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical Plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your Medical ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Exclusions: What the medical Plan will not cover

The Plan does not pay benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatments for your condition.

When benefits are limited within any of the covered health services categories described in the *Additional coverage details* section of this chapter, those limits are stated in the corresponding covered health service category in the *Plan highlights* section of this chapter. Limits may also apply to some covered health services that fall under more than one covered health service category. When this occurs, those limits are also stated in the *Plan highlights* section. Please review all limits carefully, as the Plan will not pay benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative treatments
1. Acupressure and acupuncture;
2. Aromatherapy;
3. Hypnotism;

4. Massage therapy;
5. Rolfing; and
6. Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health. This exclusion does not apply to spinal treatment and non-manipulative osteopathic care for which benefits are provided as described in the *Additional coverage details* section of this chapter.

Comfort or convenience

1. Television;
2. Telephone;
3. Beauty/barber service;
4. Guest service; and
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   a. Air conditioners;
   b. Air purifiers and filter;
   c. Batteries and battery chargers;
   d. Dehumidifiers;
   e. Humidifiers; and
   f. Devices and computers to assist in communication and speech.

Dental

1. Dental care, except as described in *Additional coverage details* under the heading *Dental services – accident only.*

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the Plan, as identified in the *Additional coverage details* section of this chapter.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   a. Extraction (including wisdom teeth), restoration and replacement of teeth;
   b. Medical or surgical treatments of dental conditions; and
   c. Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which benefits are provided as described under *Dental services – accident only* in the *Additional coverage details* section.

3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   a. Transplant preparation;
   b. Initiation of immunosuppressives;
   c. The direct treatment of acute traumatic Injury, cancer or cleft palate; and
   d. Dental anesthesia for children under 7 years of age.
6. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a congenital anomaly.

Drugs

The following exclusions apply to drugs under your medical Plan benefit. Please see the *Prescription drugs* section of this chapter for information about coverage for drugs under your prescription drug Plan benefit.

1. Prescription drug products for outpatient use that are filled by a prescription order or refill;
2. Non-injectable medications given in a physician's office except as required in an emergency;
3. Over-the-counter drugs and treatments;

4. Certain new pharmaceutical products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year;

   This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening sickness or condition, under such circumstances, Benefits may be available for the new pharmaceutical product to the extent provided for in the *Additional coverage details* section of this chapter.

5. A pharmaceutical product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. Such determinations may be made up to six times during a calendar year;
6. A pharmaceutical product that contains (an) active ingredient(s) which is(are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered pharmaceutical product. Such determinations may be made up to six times during a calendar year;
7. Benefits for pharmaceutical products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
8. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to covered persons for self-infusion; and
9. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available pharmaceutical product.

Experimental or investigational services or unproven services
Experimental or investigational services and unproven services and all services related to experimental or investigational and unproven services are excluded. The fact that an experimental or investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition.

This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided as described under *Clinical trials* in the *Additional coverage details* section of this chapter.

Foot care
1. Routine foot care, except when needed for severe systemic disease or preventive foot care for covered persons with diabetes. Routine foot care services that are not covered include:
   a. Cutting or removal of corns and calluses;
   b. Nail trimming or cutting; and
   c. Debriding (removal of dead skin or underlying tissue);
2. Hygienic and preventive maintenance foot care. Examples include the following:
   a. Cleaning and soaking the feet;
   b. Applying skin creams in order to maintain skin tone; and
   c. Other services that are performed when there is not a localized illness, injury or symptom involving the foot;
3. Treatment of flat feet;
4. Treatment of subluxation of the foot; and
5. Shoe orthotics, except as described under *Durable medical equipment (DME)* in the *Additional coverage details* section of this chapter. If you are enrolled in the BEK HSA Medical Plan, shoes (standard or custom) and foot orthotics are not covered.

Medical supplies and appliances
1. Devices used specifically as safety items or to affect performance in sports-related activities;
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   a. Ace bandages;

b. Gauze and dressings; syringes; and
c. Urinary catheters.

3. Orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable medical equipment* (DME) in the *Additional coverage details* section of this chapter. This exclusion does not apply to certain cranial orthotics as described under *Durable medical equipment* (DME) in the *Additional coverage details* section of this chapter;
4. Tubings, connectors and masks are not covered except when used with durable medical equipment as described under *Durable medical equipment* (DME) in the *Additional coverage details* section of this chapter; and
5. Powered and non-powered exoskeleton devices.

Mental health/substance use disorder

In addition to all other exclusions listed in this *Exclusions* section, the exclusions listed directly below apply to services described under *Mental health services*, *Neurobiological disorders - autism spectrum disorder services* and/or *Substance use disorder services* in the *Additional coverage details* section of this chapter.

1. Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association;
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder and paraphilic disorders;
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes;
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act;
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
7. Transitional living services;
8. Non-medical 24-hour withdrawal management; and
9. High-intensity residential care including American Society of Addiction Medicine (ASAM) criteria for covered persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment

Nutrition

1. Megavitamin and nutrition-based therapy (see the *Prescription drugs* section for coverage for prenatal vitamins under your prescription drug Plan benefit);
2. Individual and group nutritional counseling. This exclusion does not apply to nutritional counseling services that are billed as preventive care services or to nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   a. Nutritional education is required for a disease in which patient self-management is an important component of treatment; and
   b. There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
3. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which benefits are provided as described under *Enteral nutrition* in the *Additional coverage details* section; and
4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical appearance

1. Cosmetic procedures. Examples include:
   a. Pharmacological regimens, nutritional procedures or treatments;
   b. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   c. Sclerotherapy treatment of veins; and
   d. Skin abrasion procedures performed as a treatment for acne;
2. Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive procedures* in the *Additional coverage details* section of this chapter.
3. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision or for medical reasons.

   The Plan provides benefits for virtual obesity counseling services for eligible covered persons through Real Appeal. There are no deductibles, copayments or coinsurance you must meet or pay for when receiving these services.

   The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible covered persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

   This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

   These covered health services will be individualized and may include, but is not limited to, the following:
   - Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
   - Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
   - Behavioral change counseling by a specially trained coach for clinical weight loss.

   For information regarding these covered weight loss programs and services, go to realappeal.com, or call the number on your Medical ID card.

5. Wigs, except as described under *Wigs* in the *Additional coverage details* section.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
2. Services performed by a provider with your same legal residence;
3. Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other providers. Services that are self-directed to a free-standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:
   a. Has not been actively involved in your medical care prior to ordering the service; or
   b. Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography testing.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment;

   This exclusion does not apply to the services required to diagnose and/or treat any underlying causes of infertility.

2. The following services related to a gestational carrier or surrogate:
   a. All costs related to reproductive techniques including:
      i. Assistive reproductive technology;

ii. Artificial insemination;
iii. Intrauterine insemination; and
iv. Obtaining and transferring embryo(s).

b. Health care services including:
i. Inpatient or outpatient prenatal care and/or preventive care;
ii. Screenings and/or diagnostic testing; and
iii. Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the gestational carrier or surrogate is a covered person.

c. All fees including:
i. Screening, hiring and compensation of a gestational carrier or surrogate including surrogacy agency fees;
ii. Surrogate insurance premiums; and
iii. Travel or transportation fees.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
a. Donor eggs – the cost of donor eggs, including medical costs related to donor stimulation and egg retrieval; and
b. Donor sperm – the cost of procurement and storage of donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue;
5. The reversal of voluntary sterilization;
6. Invitro fertilization regardless of the reason for treatment;
7. Services provided by a doula (labor aide); and
8. Parenting, pre-natal or birthing classes.

Services provided under another plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation;

If coverage under Workers' Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness or mental Illness that would have been covered under Workers' Compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you; and
3. Health services while on active military duty.

Transplants

1. Health services for organ, multiple organ and tissue transplants, except as described in *Transplantation services* in the *Additional coverage details* section unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan.);
3. Health services for transplants involving animal organs;
4. Any solid organ transplant that is performed as a treatment for cancer; and
5. Transplants that are not performed at a designated facility. This exclusion does not apply to corneal transplants.

Travel

1. Health services provided in a foreign country, unless required as emergency health services; and
2. Travel or transportation expenses, even though prescribed by a physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

Vision and hearing

1. Purchase cost of eyeglasses, contact lenses or hearing aids. This exclusion does not apply to the initial set of eyeglasses (frames and lenses) or contact lenses following cataract surgery;
2. Fitting charge for hearing aids, eyeglasses or contact lenses;
3. Eye exercise or vision therapy;
4. Cochlear implant devices, associated surgery and post-cochlear aural therapy; and
5. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

All other exclusions

1. Health services and supplies that do not meet the definition of a covered health service. Covered health services are those health services, including services, supplies, or pharmaceutical products (see the *Prescription drugs* section), which the Claims Administrator determines to be all of the following:
   a. Medically necessary;
   b. Described as a covered health service in this chapter under the *Plan highlights* section; and
   c. Not otherwise excluded in the chapter under the *Exclusions* section.

   This exclusion does not apply to breast pumps for which benefits are provided under the *Health resources and services administration (HRSA)* requirement.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when;
   a. Required solely for purposes of career, education, sports or camp, travel, career or employment, insurance, marriage or adoption;
   b. Conducted for purposes of medical research. This exclusion does not apply to covered health services provided during a clinical trial for which benefits are provided as described under *Clinical trials* in the *Additional coverage details* section of this chapter;
   c. Related to judicial or administrative proceedings or orders; and
   d. Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends;
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
6. In the event that a non-network provider waives copayments and/or the annual deductible for a particular health service, no benefits are provided for the health service for which the copayments and/or the annual deductible are waived;
7. Charges in excess of eligible expenses or in excess of any specified limitation;
8. Non-surgical treatment of obesity, including morbid obesity;
9. Surgical treatment of obesity, including morbid obesity;
10. Growth hormone therapy;
11. Sex transformation operations;
12. Custodial care;
13. Domiciliary care;
14. Private duty nursing received on an inpatient basis;
15. Respite care;
16. Rest cures;
17. Psychosurgery;
18. Treatment of benign gynecomastia (abnormal breast enlargement in males);
19. Medical and surgical treatment of excessive sweating (hyperhidrosis);
20. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, and mastopexy;
21. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;

22. Oral appliances for snoring;
23. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or a congenital anomaly;
24. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;
25. Any charge for services, supplies or equipment advertised by the provider as free;
26. Any charges prohibited by federal anti-kickback or self-referral statutes;
27. Breast reduction surgery that is determined to be a cosmetic procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which benefits are described under *Reconstructive procedures* in the *Additional coverage details* section of this chapter;
28. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition; and
29. Intracellular micronutrient testing.

Claims procedures

Network benefits
In general, if you receive covered health services from a network provider, UnitedHealthcare will pay the physician or facility directly. If a network provider bills you for any covered health service other than your copay or coinsurance, please contact the provider or call UnitedHealthcare at the number on your Medical ID card for assistance.

Keep in mind, you are responsible for meeting the annual deductible and paying any copay or coinsurance owed to a network provider at the time of service, or when you receive a bill from the provider.

Non-network benefits
If you receive a bill for covered health services from a non-network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your Medical ID card.

Prescription drug benefit claims
If you wish to receive reimbursement for a prescription (please see the *Prescription drugs* section for information about your prescription drug Plan benefit), you may submit a post- service claim as described in this section if:
- You are asked to pay the full cost of the prescription drug when you fill it and you believe that the Plan should have paid for it; or
- You pay a copay and you believe that the amount of the copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a covered health service, you may submit a pre-service request for benefits as described in this section.

If your provider does not file your claim
You can obtain a claim form by visiting myuhc.com, calling the toll-free number on your Medical ID card or emailing benefits@benekeith.com. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:
- Your name and address.
- The patient's name, age and relationship to the participant.
- The number as shown on your Medical ID card;
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the sickness or injury began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your Medical ID card. When filing a claim for outpatient prescription drug benefits, submit your claim to the pharmacy benefit manager claims address noted on your Medical ID card.

After UnitedHealthcare has processed your claim, you will receive payment for benefits that the Plan allows. It is your responsibility to pay the non-network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of benefits

Except as required by the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260), you may not assign, transfer, or in any way convey your benefits under the Plan or any cause of action related to your benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for benefits.

The Plan will not recognize claims for benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a covered person or beneficiary, or derivatively, as an assignee of a covered person or beneficiary.

References herein to “third parties” include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a covered person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of benefits directly to a provider.

Any such payment to a provider:

- Is NOT an assignment of your benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your benefits; and
- Is NOT a waiver of the prohibition on assignment of benefits under the Plan; and
- Shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such benefits is extinguished by such payment. If any payment of your benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for benefits, and the Plan reserves the right to offset any benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans’ overpayment recovery rights to the Plan), pursuant to *Refund of overpayments* in the *Coordination of Benefits* section of this chapter.

Form of payment of benefits

Payment of benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans’ recovery rights for value.

Health statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered dependent, you will receive a health statement in the mail. Health statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered dependents online, you may do so at myuhc.com. You may also elect to discontinue receipt of paper health statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)
You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your Medical ID card to request them. You can also view and print all of your EOBs online at myuhc.com.

Timeline filing of non-network claims
All claim forms for non-network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any benefits for that eligible expense, or benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

Claim denials and appeals

If your claim is denied
If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your Medical ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to appeal a denied claim
If you wish to appeal a denied claim for benefits, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. Please see *Other events ending your coverage* in the *When coverage ends* section, for your right to appeal certain retroactive terminations of your coverage (also referred to as a "rescission of coverage").

You do not need to submit urgent care appeals in writing. This communication should include:
- The patient's name and ID number as shown on the Medical ID card;
- The provider's name;
- The date of medical service;
- The reason you disagree with the denial; and
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare – Appeals
PO Box 30432
Salt Lake City, UT 84130-0432

For urgent care requests for benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your Medical ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:
- Urgent care request for benefits;
- Pre-service request for benefits;
- Post-service claim; or
- Concurrent claim.

Urgent appeals that require immediate action
Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your Medical ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion

of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination; and
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a second appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any covered persons may examine their claim and/or appeals files(s). Covered persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any covered person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any covered person to respond to such new evidence or rationale.

External review program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons;
- The exclusions for experimental or investigational services or unproven services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your Medical ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review;
- The covered person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- The service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review; and
- An expedited external review.

Standard external review

A standard external review is comprised of all of the following:

- A preliminary review by UnitedHealthcare of the request;
- A referral of the request by UnitedHealthcare to the IRO; and
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the IRO’s request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records;
- All other documents relied upon by UnitedHealthcare; and
- All other information or evidence that you or your physician submitted. If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with UnitedHealthcare’s determination, the Plan will not be obligated to provide benefits for the health care service or procedure.

Expedited external review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability

of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

Contact UnitedHealthcare at the toll-free number on your Medical ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of appeals determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent care request for benefits – a request for benefits provided in connection with urgent care services;
- Pre-service request for benefits – a request for benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided; and
- Post-service – a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The following tables describe the time frames which you and UnitedHealthcare are required to follow.

Urgent care request for benefits*	
Type of request for benefits or appeal	**Timing**
If your request for benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** of receiving the appeal

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for benefits.

Pre-service request for benefits*	
Type of request for benefits or appeal	**Timing**
If your request for benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
If the initial request for benefits is complete, within:	**15 days**
After receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal determination

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-service claims	
Type of claim or appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
If the initial claim is complete, within:	**30 days**
After receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal determination

Concurrent care claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care request for benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of action

You cannot bring any legal action against Ben E. Keith Company or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Ben E. Keith Company or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Ben E. Keith Company or the Claims Administrator.

You cannot bring any legal action against Ben E. Keith Company or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Ben E. Keith Company or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Ben E. Keith Company or the Claims Administrator.

Coordination of Benefits (COB)

This section describes how benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Coordination of Benefits applies

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, “allowable expense,” is further explained below.

Rules for determining the order of benefit payments

Order of benefit determination rules

The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total allowable expense.

The order of benefit determination rules below govern the order in which each plan will pay a claim for benefits.

- **Primary plan.** The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses.
- **Secondary plan.** The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense. Allowable expense is defined below.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. This Ben E. Keith medical Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

C. Each plan determines its order of benefits using the first of the following rules that apply:

1. **Non-dependent or dependent**. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

2. **Dependent child covered under more than one coverage plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

      ii. If both parents have the same birthday, the plan that covered the parent longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a.) above shall determine the order of benefits.

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a. above shall determine the order of benefits.

iv. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the custodial parent.
b) The plan covering the custodial parent's spouse.
c) The plan covering the non-custodial parent.
d) The plan covering the non-custodial parent's spouse.

For purpose of this section, custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a.) or b.) above as if those individuals were parents of the child.

d. (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies. (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph a. to the dependent child's parent(s) and the dependent's spouse.

3. **Active employee or retired or laid-off employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan, and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or shorter length of coverage.** The plan that covered the person the longer period of time is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Ben E. Keith medical Plan will not pay more than it would have paid had it been the primary plan.

How benefits are paid when this Plan is secondary
If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a covered health service by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- If, based on the allowable expense, the Plan would have paid more if it were the only plan involved, the difference between the amount it would have paid and the amount it actually paid is recorded as a benefit reserve for the covered person. This reserve can be used to pay any future allowable expenses not otherwise paid by the Plan during the calendar year.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

You will be responsible for any applicable copayment, coinsurance or deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

Determining the allowable expense if this Plan is secondary
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-network provider for the primary plan and a network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the allowable expense when this plan is secondary to Medicare*.

What is different when you qualify for Medicare?

Determining which plan is primary when you qualify for Medicare
As permitted by law, this Plan will pay benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their spouses age 65 or older (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their dependents under age 65.

Determining the allowable expense when this Plan is secondary to Medicare
If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an Explanation of Medicare Benefits issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, benefits will be paid on a secondary

basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If this Plan is secondary to Medicare, it determines the amount it will pay for a covered health services by following the steps below.

1. The Plan determines the amount it would have paid had it been the only plan involved.
2. The Plan pays the entire difference between the allowable expense and the amount paid by the primary Plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

The maximum combined payment you may receive from all plans cannot exceed 100% of the applicable allowable expense.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and durable medical equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your Medical ID card.

Right to receive and release needed information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for benefits will be denied.

Right of recovery

Overpayment and underpayment of benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of overpayments*, below.

Refund of overpayments

If the Plan pays for benefits for expenses incurred on account of a covered person, that covered person or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits that are payable in connection with services provided to other covered persons under the Plan; or (ii) future benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- Equal the amount of the required refund, or
- If less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Subrogation and reimbursement

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which any third party is considered responsible.

Example of subrogation
Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Example of reimbursement
Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.

- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.

- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan benefits provided on behalf of the covered person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan’s rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy – including no-fault benefits, Personal Injury Protection (PIP) benefits and/or medical payment benefits – other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan’s right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer’s legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate’s name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan’s right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to you, your dependents or the participant, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan’s subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan’s subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of recovery
The Plan also has the right to recover benefits it has paid on you or your dependent's behalf that were:
- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year deductible.
- Advanced during the time period of meeting the out-of-pocket maximum for the calendar year.
- Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:
- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:
- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

When coverage ends

Your entitlement to benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended coverage for total disability* later in this chapter.

When your coverage ends, Ben E. Keith Company will still pay claims for covered health services that you received before your coverage ended. However, once your coverage ends, benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended coverage for total disability* later in this chapter.

Your coverage under the Plan will end on the earliest of:
- The last day of the month your employment with the Company ends;
- The date the Plan ends;
- The last day of the month you stop making the required contributions;
- The last day of the month you are no longer eligible;
- The last day of the month UnitedHealthcare receives notice from Ben E. Keith Company to end your coverage, or the date requested in the notice, if later; or
- The last day of the month you retire or are pensioned under the Plan.

Coverage for your eligible dependents will end on the earliest of:
- The date your coverage ends;
- The last day of the month you stop making the required contributions;
- The last day of the month UnitedHealthcare receives notice from Ben E. Keith Company to end your coverage, or the date requested in the notice, if later; or
- The last day of the month your dependents no longer qualify as dependents under this Plan.

Other events ending your coverage
The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if:
- You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent; or
- You commit an act of physical or verbal abuse that imposes a threat to Ben E. Keith Company's staff, UnitedHealthcare's staff, a provider or another covered person.

You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: Ben E. Keith Company has the right to demand that you pay back benefits Ben E. Keith Company paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Surviving dependents continuation
Upon death of an active employee, the surviving spouse and any eligible dependents covered under the Plan at the date of the employee's death will be eligible to continue medical/prescription drug coverage for up to 12 months at no cost. The Company will pay 100% of the cost during any surviving eligible dependent's continuation period. The 12-month continuation period will begin on the first of the month following the month in which the employee died and will cease on the last day of the 12th month of continuation. At the end of any surviving eligible dependent's continuation period, the eligible dependent will be offered COBRA continuation.

Coverage for a disabled child
If an unmarried enrolled dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- The child is unable to be self-supporting due to a mental or physical handicap or disability;
- The child depends mainly on you for support;
- You provide to Ben E. Keith Company proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- You provide proof, upon Ben E. Keith Company's request, that the child continues to meet these conditions.

The proof might include medical examinations at Ben E. Keith Company's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay benefits for that child.

Coverage will continue, as long as the enrolled dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Leave of absence
If active work ceases during an approved layoff, non-medical or personal leave of absence, or medical leave of absence, coverage can be continued for up to 12 months from the date the individual stopped active work. Coverage may extend beyond 12 months if the employee is on company approved salary continuation.

Absences which exceed twelve months in length shall require annual renewal of medical documentation provided to the employee by the Company. Renewal of coverage under this policy ceases on the earlier of the following events:

- Participant attaining age 65.
- Participant is released to return to work by his/her attending physician.
- Participant fails to return to Company the initial and/or annual medical documentation.
- Initial and/or annual medical documentation fails to support inability to work at Ben E. Keith Company.
- Participant begins working for any wage or profit for any other company while receiving a salary continuation benefit from Ben E. Keith Company.

Extended coverage for total disability
If a covered person has a total disability on the date their coverage under the Plan ends, their benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the total disability. Benefits will be paid until the earlier of:

- The total disability ends; or
- Three months from the date coverage would have ended.

Continuing coverage through COBRA
If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Continuation coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "qualified beneficiary". A qualified beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- A participant;
- A participant's enrolled dependent, including with respect to the participant's children, a child born to or placed for adoption with the participant during a period of continuation coverage under federal law; or
- A participant's spouse.

Qualifying events for continuation coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If coverage ends because of the following qualifying events:	You may elect COBRA…		
	For yourself	For your spouse	For your child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or another qualified beneficiary becomes eligible for Social Security disability benefits[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Ben E. Keith Company files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the qualified beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the qualified beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the qualified beneficiary entitled to the 11 months of coverage has non-disabled family members who are also qualified beneficiaries, then those non-disabled qualified beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the qualified beneficiary is no longer disabled must be provided within 30 days of such determination.

Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any retired participant and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the participant's death if the participant dies during the continuation coverage.

How your Medicare eligibility affects dependent COBRA coverage
The table below outlines how your dependents' COBRA coverage is impacted if you become entitled to Medicare.

If dependent coverage ends when:	You may elect COBRA dependent coverage for up to:
You become entitled to Medicare and don't experience any additional qualifying events	**18 months**
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	**36 months**
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of dependent coverage under the Plan	**36 months**

*Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting started
You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both participant and employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:
- During Annual Enrollment; and
- Following a qualified life event, as described in the **Eligibility and enrollment** chapter.

Notification requirements
If your covered dependents lose coverage due to divorce, legal separation, or loss of dependent status, you or your dependents must notify the Plan Administrator within 60 days of the latest of:
- The date of the divorce, legal separation or an enrolled dependent's loss of eligibility as an enrolled dependent;
- The date your enrolled dependent would lose coverage under the Plan; or
- The date on which you or your enrolled dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your dependents must also notify the Plan Administrator when a qualifying life event occurs that will extend continuation coverage.

If you or your dependents fail to notify the Plan Administrator of these events within the 60-day period, the Plan Administrator is not obligated to provide continued coverage to the affected qualified beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification requirements for disability determination
If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in the **Plan administration and ERISA rights** chapter.

The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving Trade Adjustment Assistance (TAA) or “alternative trade adjustment assistance” under a federal law called the Trade Act of 1974. These participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- The date, after electing continuation coverage, that you or your covered dependent first becomes entitled to Medicare;
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- The date the entire Plan ends; or
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the participant and the participant's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a participant's behalf. If a participant's Military Service is for a period of time less than 31 days, the participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24-month period beginning on the date of the participant's absence from work; or
- The day after the date on which the participant fails to apply for, or return to, a position of employment.

Regardless of whether a participant continues health coverage, if the participant returns to a position of employment, the Participant's health coverage and that of the participant's eligible dependents will be reinstated under the Plan.

No exclusions or waiting period may be imposed on a participant or the participant's eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Other important information

Qualified Medical Child Support Orders (QMCSOs)
A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your dependent, and the Plan will be required to pay benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing a QMCSO from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your relationship with UnitedHealthcare and Ben E. Keith Company
In order to make choices about your health care coverage and treatment, Ben E. Keith Company believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled.

UnitedHealthcare does not provide medical services or make treatment decisions. This means:
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for covered health services, which are more fully described in this SPD); and
- The Plan may not pay for all treatments you or your physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Ben E. Keith Company and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Ben E. Keith Company and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Ben E. Keith Company and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with providers
The Claims Administrator has agreements in place that govern the relationships between it and Ben E. Keith Company and network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide covered health services to covered persons.

Ben E. Keith Company and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Ben E. Keith Company and UnitedHealthcare arrange for health care providers to participate in a network and pay benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Ben E. Keith Company's employees nor are they employees of UnitedHealthcare. Ben E. Keith Company and UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Ben E. Keith Company is solely responsible for:
- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);

- The timely payment of benefits; and
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., the Claims Administrator is not the administrator of the Plan or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor.

Your relationship with providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- Are responsible for choosing your own provider;
- Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including copayments, coinsurance, any annual deductible and any amount that exceeds eligible expenses;
- Are responsible for paying, directly to your provider, the cost of any non-covered health service;
- Must decide if any provider treating you is right for you (this includes network providers you choose and providers to whom you have been referred); and
- Must decide with your provider what care you should receive.

Interpretation of benefits

Ben E. Keith Company and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret benefits under the Plan;
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the *Schedule of Benefits* and any addendums, Summary of Material Modifications (SMM) and/or amendments; and
- Make factual determinations related to the Plan and its benefits.

Ben E. Keith Company and UnitedHealthcare may delegate this discretionary authority to other persons or entities, including the Claims Administrator’s affiliates, that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, Ben E. Keith Company may, in its discretion, offer benefits for services that would otherwise not be covered health services. The fact that Ben E. Keith Company does so in any particular case shall not in any way be deemed to require Ben E. Keith Company to do so in other similar cases.

Information and records

Ben E. Keith Company and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Ben E. Keith Company and UnitedHealthcare may request additional information from you to decide your claim for benefits. Ben E. Keith Company and UnitedHealthcare will keep this information confidential. Ben E. Keith Company and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Ben E. Keith Company and UnitedHealthcare with all information or copies of records relating to the services provided to you. Ben E. Keith Company and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all covered persons, including enrolled dependents whether or not they have signed the participant's enrollment form. Ben E. Keith Company and UnitedHealthcare agree that such information and records will be considered confidential.

Ben E. Keith Company and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or

quality assessment, or as Ben E. Keith Company is required to do by law or regulation. During and after the term of the Plan, Ben E. Keith Company and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Ben E. Keith Company recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Ben E. Keith Company and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to providers
Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness;
- A practice called capitation which is when a group of network providers receives a monthly payment from UnitedHealthcare for each covered person who selects a network provider within the group to perform or coordinate certain health services. The network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the covered person's health care is less than or more than the payment; or
- Bundled payments – certain network providers receive a bundled payment for a group of covered health services for a particular procedure or medical condition. The applicable copayment and/or coinsurance will be calculated based on the provider type that received the bundled payment. The network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the covered person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional copayment and/or coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some covered health services that are not considered part of the inclusive bundled payment and those covered health services would be subject to the applicable copayment and/or coinsurance as described in the *Schedule of Benefits* in the *Plan highlights* section earlier in this chapter.

The Claims Administrator uses various payment methods to pay specific network providers. From time to time, the payment method may change. If you have questions about whether your network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your Medical ID card. The Claims Administrator can advise whether your network provider is paid by any financial incentive, including those listed above.

Incentives to you
Sometimes you may be offered coupons, enhanced benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from designated providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but Ben E. Keith Company recommends that you discuss participating in such programs with your physician. These incentives are not benefits and do not alter or affect your benefits. You may call the number on your Medical ID card if you have any questions. Additional information may be found in the *Clinical programs and resources* section of this chapter.

Rebates and other payments
Ben E. Keith Company and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a physician's office, or at a hospital or alternate facility. This includes rebates for those drugs that are administered to you before you meet your annual deductible. Ben E. Keith Company and UnitedHealthcare may pass a portion

of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your copays or coinsurance.

Workers' Compensation not affected
Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance.

Future of the Plan
Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, covered persons will not have the right to any other benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, covered persons may be subject to altered coverage and benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan document
This Summary Plan Description (SPD) represents an overview of your benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document for a nominal fee by providing a written request to the Plan Administrator.

Review and determine benefits in accordance with UnitedHealthcare reimbursement policies
UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- As reported by generally recognized professionals or publications;
- As used for Medicare; and
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with physicians and other providers in UnitedHealthcare's network through UnitedHealthcare's provider website. Network physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-network physician or provider by going to myuhc.com or by calling the telephone number on your Member ID card.

UnitedHealthcare may apply a reimbursement methodology established by OptumInsight and/or a third-party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for emergency health care services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an emergency health care service. If the methodology(ies) currently in use become no longer available,

UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at myuhc.com for information regarding the vendor that provides the applicable methodology.

Prescription drugs

The table below provides an overview of the Plan's prescription drug coverage. It includes copay amounts that apply when you have a prescription filled at a network pharmacy. For detailed descriptions of your benefits, refer to the *Retail* and *Mail order* sections of this chapter.

Depending on the plan you enroll in, you will pay a copay vs. a coinsurance.

- If you enroll in the BEK PPO Medical Plan, you will pay a copay every time you fill a prescription.
  - An annual prescription drug deductible of $75 applies to your benefits, which is separate from the annual deductible for your medical coverage. Copays do not apply toward the annual prescription drug deductible.
  - The out-of-pocket maximum applies to all covered health services under the Plan, including covered health services provided in the *Additional coverage details* section of this chapter.
- If you enroll in the BEK HSA Medical Plan, you will pay a coinsurance for prescription drug benefits.
  - The annual deductible applies to all covered health services under the Plan, including covered health services provided in the *Additional coverage details* section of this chapter. The out-of-pocket maximum applies to all covered health services under the Plan, including covered health services provided in the *Additional coverage details* section.

Prescription drug coverage[1, 2]	BEK PPO Medical Plan	BEK HSA Medical Plan
Retail – up to a 31-day supply[5, 6] When a prescription drug product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the copayment that applies will reflect the number of days dispensed or days the drug will be delivered. Tier 1[3, 4] Tier 2[3] Tier 3	100% after you meet the annual prescription drug deductible and pay the following copay: $15 $35 $75	You pay 30% coinsurance after you meet your annual deductible; use money in your HSA or pay out of your own pocket
Mail order – up to a 90-day supply Tier 1[3] Tier 2[3] Tier 3	100% after you pay the following copay: $30 $70 $150	You pay 30% coinsurance after you meet your annual deductible; use money in your HSA or pay out of your own pocket

[1]You must obtain prior authorization from UnitedHealthcare to receive full benefits for certain prescription drugs. Otherwise, you may pay more out-of-pocket. See *Prior authorization requirements* in this section for details.

[2]You are not responsible for paying a copayment and/or coinsurance for preventive care medications.

[3]Certain medications that are commonly prescribed to people with high blood pressure and high cholesterol, diabetes or pre-diabetes that are in tier-1 or tier-2 are available at no cost. See *Enhanced benefits* in the *Plan highlights* section for additional information. Medications that are in tier-3 will not be paid at a waived copay or coinsurance. Instead, these medications will be paid according to the table in this section.

[4]PPO Plan only: tier-1 FDA approved contraceptives are covered at 100%, in accordance with health care reform.

[5]A 90-day supply is allowed at a retail pharmacy only if the retail pharmacy is willing to fill/refill the prescription drug for amounts up to this quantity. Please remember that any fill/refill of 32-days to 90-days at a retail pharmacy will be subject to two times the retail copay or coinsurance identified in the table. This does not apply to specialty prescription drugs, which only allow for a 31-day supply.

[6]Specialty prescription drugs are covered by the Plan. See *Specialty prescription drug products* for additional specialty prescription drug coverage details.

Note: The Coordination of Benefits provision described in the *Coordination of Benefits (COB)* section of this chapter applies to covered prescription drugs as described in this section. Benefits for prescription drugs will be coordinated with those of any other health plan in the same manner as benefits for covered health services described in this SPD.

Medical identification card (Member ID card) – network pharmacy
You must either show your Medical ID card at the time you obtain your prescription drug at a network pharmacy or you must provide the network pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your Medical ID card or provide verifiable information at a network pharmacy, you will be required to pay the usual and customary charge for the prescription drug at the pharmacy.

Submit claims to:

Optum Rx
P.O. Box 29077
Hot Springs, AR 71903

Benefit levels
Benefits are available for outpatient prescription drugs that are considered covered health services. As a reminder, if you enroll in the BEK PPO Medical Plan, you will pay a copay after the prescription drug deductible of $75. If you enroll in the BEK HSA Medical Plan, you will pay a coinsurance after you meet the annual deductible.

The Plan pays benefits at different levels for tier-1, tier-2 and tier-3 prescription drugs. The Plan pays benefits at the same level for tier-1, tier-2 and tier-3 prescription drugs. All prescription drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a prescription drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a prescription drug, depending on its tier assignment. Since the PDL may change periodically, you can visit myuhc.com or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a copay or coinsurance, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your copay or coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service – see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest copay or coinsurance option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your physician decide they are appropriate for your treatment.
- Tier-2 is your middle copay or coinsurance option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest copay or coinsurance option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

For prescription drugs at a retail network pharmacy, you are responsible for paying the lower of:

- The applicable copay or coinsurance;
- The network pharmacy's usual and customary charge for the prescription drug product; or
- The prescription drug charge for that prescription drug product.

For prescription drugs from a mail order network pharmacy, you are responsible for paying the lower of:

- The applicable copay or coinsurance; or
- The prescription drug charge for that particular prescription drug.

Retail
The Plan has a network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about network pharmacies by contacting UnitedHealthcare at the toll-free number on your Member ID card or by logging onto myuhc.com.

To obtain your prescription from a network pharmacy, simply present your Medical; ID card and pay the copay or coinsurance. The Plan pays benefits for certain covered prescription drugs:

- As written by a physician;
- Up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- When a prescription drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the copay or coinsurance that applies will reflect the number of days dispensed; and
- Up to a 90-day supply at a retail pharmacy as long as the retail pharmacy is willing to fill/refill the prescription drug up to a 90-day supply.

If you purchase a prescription drug from a non-network pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Network pharmacy benefits apply only if your prescription is for a covered health service, and not for experimental or investigational, or unproven services. Otherwise, you are responsible for paying 100% of the cost.

Mail order

The mail order service may allow you to purchase up to a 90-day supply of a covered drug through the mail from a network pharmacy.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your Medical ID card.

The Plan pays mail order benefits for certain covered prescription drugs:

- As written by a physician; and
- Up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

Note: To maximize your benefit, ask your physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order copay or coinsurance for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for preventive care medications

Benefits under the prescription drug Plan include those for preventive care medications as defined in *Glossary – prescription drugs* at the end of this section. You may determine whether a drug is a preventive care medication on myuhc.com or by calling UnitedHealthcare at the toll-free number on your Medical ID card.

Designated pharmacies

If you require certain prescription drug products, including, but not limited to, specialty prescription drug products, UnitedHealthcare may direct you to a designated pharmacy with whom it has an arrangement to provide those prescription drug products.

Smart Fill Program – split fill prescriptions

Certain specialty prescription drug products may be dispensed by the designated pharmacy in 15-day supplies up to 90 days and at a pro-rated copayment or coinsurance. The covered person will receive a 15-day supply of their specialty prescription drug product to determine if they will tolerate the specialty prescription drug product prior to purchasing a full supply. The designated pharmacy will contact the covered person each time prior to dispensing the 15-day supply to confirm if the covered person is tolerating the specialty prescription drug product. You may find a list of specialty prescription drug products included in the Smart Fill Program, online at myuhc.com or by calling the telephone number on your Medical ID card.

Specialty prescription drug products
Benefits are provided for specialty prescription drug products. If you require specialty prescription drug products, UnitedHealthcare may direct you to a designated pharmacy with whom UnitedHealthcare has an arrangement to provide those specialty prescription drug products.

If you are directed to a designated pharmacy and you choose not to obtain your specialty prescription drug product from a designated pharmacy, no benefit will be paid for that specialty prescription drug product.

Assigning prescription drugs to the PDL
UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of prescription drug placement in tiers. In its evaluation of each prescription drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- Evaluations of the place in therapy;
- Relative safety and efficacy; and
- Whether supply limits or notification requirements should apply.

Economic factors may include:

- The acquisition cost of the prescription drug; and
- Available rebates and assessments on the cost effectiveness of the prescription drug.

Some prescription drugs are most cost effective for specific indications as compared to others, therefore, a prescription drug may be listed on multiple tiers according to the indication for which the prescription drug was prescribed.

When considering a prescription drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding covered persons as a general population. Whether a particular prescription drug is appropriate for an individual covered person is a determination that is made by the covered person and the prescribing physician.

The PDL Management Committee may periodically change the placement of a prescription drug among the tiers.

Prior authorization requirements
Before certain prescription drugs are dispensed to you, it is the responsibility of your physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare. UnitedHealthcare will determine if the prescription drug, in accordance with UnitedHealthcare's approved guidelines, is both:

- A covered health service as defined by the Plan; and
- Not experimental or investigational or unproven.

The Plan may also require you to obtain prior authorization from UnitedHealthcare so UnitedHealthcare can determine whether the prescription drug product, in accordance with its approved guidelines, was prescribed by a specialist physician.

Network pharmacy prior authorization
When prescription drugs are dispensed at a network pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from the Claims Administrator.

If you do not obtain prior authorization before the prescription drug is dispensed, you may pay more for that prescription drug order or refill. You will be required to pay for the prescription drug at the time of purchase. If you do not obtain prior authorization before you purchase the prescription drug, you can request reimbursement after you receive the prescription drug - see the *Claims procedures* section for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization before the prescription drug was dispensed. The amount you are reimbursed will be based on the prescription drug charge (for prescription drugs from a network pharmacy) less the required copay and/or coinsurance and any deductible that applies.

To determine if a prescription drug requires prior authorization, either visit myuhc.com or call the toll-free number on your Medical ID card. The prescription drugs requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the prescription drug after the Claims Administrator reviews the documentation provided and determines that the prescription drug is not a covered health service or it is an experimental or investigational or unproven service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at myuhc.com or by calling the toll-free number on your Medical ID card.

Prescription drug benefit claims
For prescription drug claims procedures, please refer to the *Claims procedures* section of this chapter.

Limitation on selection of pharmacies
If UnitedHealthcare determines that you may be using prescription drugs in a harmful or abusive manner, or with harmful frequency, your selection of network pharmacies may be limited. If this happens, you may be required to select a single network pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single network pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single network pharmacy for you.

Supply limits
Some prescription drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a prescription drug has been assigned a maximum quantity level for dispensing, either visit myuhc.com or call the toll-free number on your Medical ID card. Whether or not a prescription drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a brand-name drug becomes available as a generic
If a brand-name prescription drug becomes available as a generic drug, the tier placement of the brand-name drug may change. As a result, your copay and/or coinsurance may change. You will pay the copay and/or coinsurance applicable for the tier to which the prescription drug is assigned.

Special programs
Ben E. Keith Company and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs online at myuhc.com or by calling the number on your Member ID card.

Coupons, incentives and other communications
At various times, UnitedHealthcare may send mailings or provide other communications to you, your physician or your pharmacy that communicate a variety of messages, including information about prescription drug products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your physician can determine whether a change in your prescription and/or non-prescription drug regimen is appropriate for your medical condition.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your copay and/or coinsurance or apply to your annual drug deductible. You may access information on which coupons or offers are not permitted online at myuhc.com or by calling the number on your Medical ID card.

Exclusions – what the prescription drug Plan will not cover
Exclusions from coverage listed in the *Exclusions* section of this chapter apply also to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain prescription drugs, you can access more information on which prescription drugs are excluded by visiting myuhc.com or calling the telephone number on your Medical ID card.

Medications that are:

1. For any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
2. Any prescription drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
3. Available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the- counter medication as eligible for coverage as if it were a prescription drug and it is obtained with a prescription order or refill from a physician. Prescription drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain prescription drugs that the Plan Administrator has determined are therapeutically equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate benefits for a prescription drug that was previously excluded under this provision;
4. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available prescription drug product;
5. Dispensed by a non-network pharmacy;
6. Dispensed outside of the United States, except in an emergency;
7. Durable medical equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
8. Certain prescription drugs for tobacco cessation;
9. Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
10. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
11. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
12. Certain new prescription drugs and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator’s Prescription Drug List (PDL) Management Committee;
13. prescribed, dispensed or intended for use during an inpatient stay;
14. prescribed for appetite suppression, and other weight loss products;
15. prescribed to treat infertility;
16. Prescription drugs, including new prescription drugs or new dosage forms, that UnitedHealthcare and Ben E. Keith Company determines do not meet the definition of a covered health service;
17. A prescription drug product that contains (an) active ingredient(s) available in and therapeutically equivalent to another covered prescription drug product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a prescription drug product that was previously excluded under this provision;
18. A prescription drug product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent to another covered prescription drug product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a prescription drug product that was previously excluded under this provision;
19. Certain prescription drug products for which there are therapeutically equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a prescription drug Product that was previously excluded under this provision;
20. Typically administered by a qualified provider or licensed health professional in an outpatient setting;
21. Certain unit dose packaging or repackagers of prescription drugs;

22. Used for conditions and/or at dosages determined to be experimental or investigational, or unproven, unless UnitedHealthcare and Ben E. Keith Company have agreed to cover an experimental or investigational or unproven treatment.
23. Used for cosmetic purposes;
24. Vitamins, except for the following which require a prescription:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
25. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of sickness or injury;
26. A prescription drug product that contains marijuana, including medical marijuana;
27. A prescription drug product with an approved biosimilar or a biosimilar and therapeutically equivalent to another covered prescription drug product. For the purpose of this exclusion a "biosimilar" is a biological prescription drug product approved based on showing that it is highly similar to a reference product (a biological prescription drug product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate benefits for a prescription drug product that was previously excluded under this provision;
28. Publicly available software applications and/or monitors that may be available with or without a prescription order or refill;
29. Prescription drugs as a replacement for a previously dispensed prescription drug product that was lost, stolen, broken or destroyed;
30. Certain prescription drugs that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a prescription drug; and
31. A pharmaceutical product for which benefits are provided in the medical portion of the Plan.

This exclusion includes certain forms of vaccines/immunizations. It does not include preventive vaccines, including influenza.

This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Glossary – prescription drugs

Brand-name. A prescription drug that is either:
- Manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- Identified by UnitedHealthcare as a brand-name drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand-name or generic based on a number of factors.

You should know that products identified as "brand name" by the manufacturer, pharmacy, or your physician may not be classified as brand-name by UnitedHealthcare.

Designated pharmacy. A pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific prescription drug products including, but not limited to, specialty prescription drug products. The fact that a pharmacy is a network pharmacy does not mean that it is a designated pharmacy.

Diabetes-related condition. A diagnosis of diabetes or pre-diabetes based on a covered person’s claim history or completion of a valid diagnosis verification by the covered person’s physician or a fasting blood glucose level greater than 99.

Generic. A prescription drug that is either:
- Chemically equivalent to a brand-name drug; or
- Identified by UnitedHealthcare as a generic drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either brand-name or generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your physician may not be classified as a generic by UnitedHealthcare.

Network pharmacy. A retail or mail order pharmacy that has:

- Entered into an agreement with UnitedHealthcare to dispense prescription drugs to covered persons;
- Agreed to accept specified reimbursement rates for prescription drugs; and
- Been designated by UnitedHealthcare as a network pharmacy.

PDL. See *Prescription Drug List (PDL).*

PDL Management Committee. *See Prescription Drug List (PDL) Management Committee*.

Prescription drug (or prescription drug product). A medication or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A prescription drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of benefits under this Plan, this definition includes:

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood testing strips – glucose;
  - Urine testing strips – glucose
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices;
  - Insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
  - Glucose meters including continuous glucose monitors (CGMs); and
- Certain vaccines/immunizations administered in a network pharmacy for preventive care, including flu and COVID; and
- Certain injectable medications administered in a network pharmacy.

Prescription drug charge. The rate the Plan has agreed to pay UnitedHealthcare on behalf of its network pharmacies, including the applicable dispensing fee and any applicable sales tax, for a prescription drug product dispensed at a network pharmacy.

Prescription Drug List (PDL). A list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to UnitedHealthcare's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular prescription drug has been assigned by contacting UnitedHealthcare at the number on your Medical ID card or by logging onto myuhc.com.

Prescription Drug List (PDL) Management Committee. The committee that UnitedHealthcare designates for, among other responsibilities, classifying prescription drugs into specific tiers.

Preventive care medications (PPACA zero cost share). The medications that are obtained at a network pharmacy and that are payable at 100% of the prescription drug charge (without application of any copay, coinsurance, annual deductible, annual prescription drug deductible or specialty prescription drug annual deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a preventive care medication as well as information on access to coverage of medically necessary alternatives on myuhc.com or by calling UnitedHealthcare at the toll-free number on your Medical ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

Specialty prescription drug product. Prescription drug products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of specialty prescription drug products online at myuhc.com or by calling the telephone number on your Medical ID card.

Therapeutically equivalent. When prescription drugs have essentially the same efficacy and adverse effect profile.

Usual and customary charge. The usual fee that a pharmacy charges individuals for a prescription drug without reference to reimbursement to the pharmacy by third parties. The usual and customary charge includes a dispensing fee and any applicable sales tax.

Important administrative information

Agent for Service of Legal Process
Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – Medical Plan
Ben E. Keith Company
601 East 7th Street
Fort Worth, TX 76102
1-817-877-5700

Legal process may also be served on the Plan Administrator.

Patient Protection and Affordable Care Act ("PPACA")

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on your Medical ID card.

For children, you may designate a pediatrician as the primary care provider.

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

Nondiscrimination and accessibility requirements

When the Plan uses the words "Claims Administrator" in this attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters.
- Information written in other languages.

If you need these services, please call the toll-free member number on your Medical ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

ERISA rights
For more information about your rights and protections under ERISA, see the **Plan administration and ERISA rights** chapter of this SPD.

Claims Administrator Civil Rights Coordinator
If you need help filing a grievance, the Civil Rights Coordinator listed below can help.

United HealthCare Services, Inc.
Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You can also call the toll-free member phone number listed on your Medical ID card, TTY 711 or email UHC_Civil_Rights@UHC.com.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or by mail at:

- https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
- http://www.hhs.gov/ocr/office/file/index.html for complaint forms.
- 1-800-368-1019, 1-800-537-7697 (TDD), toll free
- U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201.

Getting help in other languages or formats
You have the right to get help and information in your language at no cost. To request an interpreter or to request the document in another format, call the toll-free member phone number listed on your Medical ID card, and press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Flexible Spending Accounts (FSAs)

You can elect to establish two Flexible Spending Accounts ("FSAs") that let you make before-tax contributions from your salary, which can then be used to reimburse yourself for eligible expenses.

Ben E. Keith offers you the opportunity to enroll in a health care and dependent care account each year.

BEK Health Care FSA
The BEK Health Care FSA (also known as the "Health Care Spending Account/HCSA") is a type of FSA used for reimbursement of eligible health care expenses including certain medical and dental expenses for you, your spouse, your dependent children and any other eligible dependents as determined by Ben E. Keith Company and in compliance with the Internal Revenue Code (IRC). See the *Health Care Spending Account* section of this chapter for a list of eligible expenses.

Note: If you enroll in the BEK HSA Medical Plan, you are eligible to enroll in what's called a Limited Health Care FSA which is a type of FSA used for reimbursement of certain vision and dental expenses. You can use money in your HSA to reimburse yourself for eligible medical health care expenses. The Limited Health Care FSA "limits" the type of expenses to vision and dental only, because when you enroll in an HSA medical plan, you will have dollars in that account to pay for reimbursable medical expenses.

When you go online to enroll, the health care FSA plan you are eligible to participate in will automatically be displayed. So although there are two types of health care FSAs, you will only be able to choose the plan available to you. Later in this chapter, you can find a list of Limited Health Care FSA eligible expenses and additional information that you need to know if you decide to enroll in this plan as well as a health savings account (HSA) medical plan.

BEK Dependent Care FSA
The BEK Dependent Care FSA (also known as the "Dependent Care Spending Account/DCSA") is a type of FSA used for reimbursement of eligible dependent care expenses such as day care. See the *Dependent Care Spending Account* section for additional information.

You can elect to participate in either the BEK Dependent Care FSA or the BEK Health Care FSA, or both.

Each Plan year (January 1st through December 31st you can contribute to either of the available FSAs, and then, during the Plan year, receive reimbursement from the appropriate account for eligible expenses that are not otherwise reimbursed. Contribution amounts and limits are shown in the *Contributions* section of this chapter).

Who is eligible

A regular full-time employee of Ben E. Keith who is scheduled to work at his or her job at least 30 hours per week or, a part-time employee who is scheduled to work at least 1,000 a year, are eligible to participate in the FSA plans. COBRA participants may participate in a health care FSA; but, are not eligible to participate in the BEK Dependent Care FSA.

How to enroll

To enroll, go to dayforcehcm.com, click on *Benefits*, then on *Start Enrollment*. You must complete your enrollment by the first of the month following 60 days of employment or if you are a Southeast Division or Kelley Manufacturing employee, by the first of the month following 30 days of employment. If you do not enroll when you first become eligible, you will need to wait until the next Annual Enrollment period to make your benefit elections

Each year during Annual Enrollment, you have the opportunity to review and change the amount of before-tax dollars you wish to contribute to the either (or both) of the FSAs. Any changes you make during Annual Enrollment will become effective on the following January 1st.

Contributions

Each year, you must decide on the amount of before-tax dollars you want to contribute to the accounts. FSAs are not "funded" but rather, the amount you elect to "contribute" remains in the Company's general assets until claims are reimbursed. You may contribute to either (or both) of the available FSAs, however, amounts contributed to one account cannot be used to reimburse expenses under the other FSA. Be sure to carefully estimate your eligible health care and dependent care expenses, (referred to throughout this chapter as "eligible expenses"), for the upcoming Plan year.

Contribution limits

You may elect to contribute an amount up to $2,750 in 2022 if you enroll in the BEK Health Care FSA.

If you choose to enroll in the BEK Dependent Care FSA, you may elect to contribute an amount up to $5,000, or if you are married and filing separately for federal income tax purposes, you may each elect to contribute up to $2,500 a year. If you or your spouse's earned income is less than $5,000 per year, the amount that you can contribute is reduced to the amount of your or your spouse's earned income.

How the Plans work

BEK Health Care FSA (and Limited Health Care Spending Account)

IRS regulations permit the forfeiture of any unused funds remaining in these accounts at the end of the Plan year except that a portion of your remaining health care FSA funds may automatically roll over into your account for the next plan year.

You have until March 31st of the next year to request reimbursement for eligible expenses incurred during the Plan year.

A portion of your remaining health care FSA funds will automatically roll over into your account for the next Plan year.

If you don’t spend all the funds in your FSA during the initial year, your employer allows a portion of your remaining FSA balance to automatically roll over into your account for another Plan year. The maximum amount that can be rolled over at the end of the 2022 Plan year is limited to $550.

The Plan allows you to spend down the remaining balance in the BEK Health Care FSA even if you do not re-enroll in the BEK Health Care FSA. The rollover is available indefinitely.

Your rollover amount may be used to pay or reimburse medical expenses incurred during the entire Plan year to which it is carried over. New Plan year expenses are reimbursed from the new Plan year’s salary reduction election first. This allows the carryover amount to remain available for the prior Plan year’s expenses during the run-out period. There is no “grace period” allowed.

BEK Dependent Care FSA

IRS regulations require that you forfeit any unused funds remaining in the account at the end of the Plan year, including those unused funds remaining after a 2½ month period immediately following the end of the Plan year.

You have until March 31st of the next year to request reimbursement for eligible expenses incurred during the Plan year.

If your employment terminates you can continue to request reimbursement for eligible dependent care expenses incurred until the earlier of the date your balance will be exhausted or the end of the Plan year following your employment termination date against what is in your account at the time of termination. The dates of service must fall within the Plan year in which your account termed. Any such eligible dependent care expenses must be submitted on or before March 31st of the Plan year following your termination.

Since a grace period is offered under this Plan for the BEK Dependent Care FSA, rollovers are not allowed.

Changing your contribution amounts

IRS regulations do not permit you to stop or change the amount you contribute to flexible spending accounts during the Plan year, unless you meet one of the following conditions:

A. One of the following changes in status events must occur:

- An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
- An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
- An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence.
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age, student status or any similar circumstances.

B. For individuals who participate in the BEK Health Care FSA, the following additional events will enable you to change your election:

- If you become entitled to Medicare or Medicaid, you may elect to revoke your BEK Health Care FSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
- If the FSA Plan Sponsor receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator may:
  - Change your election to provide coverage for that child, if the order requires you to provide coverage for the child under the BEK Health Care FSA.
  - Permit you to cancel your child's coverage under the BEK Health Care FSA, if the order requires your former spouse to provide coverage.

C. For individuals who participate in the BEK Dependent Care FSA, the following events, in addition to those in A. above will enable you to change your election:

- A change in your dependent care provider.
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify Ben E. Keith Company within 31 days of above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your health care FSA election). As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.

Eligible BEK Health Care FSA expenses

To be eligible for reimbursement, your health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.
- Incurred while you are participating in the BEK Health Care FSA.
- Incurred during the Plan year.

IMPORTANT NOTE: Any reimbursement you receive through your BEK Health Care FSA cannot be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your health care FSA. Generally, eligible health care expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

A more comprehensive list of eligible expenses is available at myuhc.com. Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, IRS website irs.gov or by phone at 1-800-TAX-FORM (1-800-829-3676).

Eligible medical expenses

- Copayments, coinsurance and deductible amounts.
- Routine physical exams.
- Routine lab and X-rays performed for medical reasons.
- Birth control items prescribed by your doctor.
- Childbirth classes.
- Cardiac rehabilitation classes.
- Drug abuse treatment centers.
- Sterilization unless prohibited by law.
- Other qualified 213(d) medical expenses not covered by the underlying medical plan.

Eligible vision expenses

- Routine eye examinations.
- Eye glasses.
- Contact lenses, including all necessary supplies and equipment.

Eligible hearing expenses

- Routine hearing examinations.
- Hearing aids and repairs.
- Cost and repair of special telephone equipment for the deaf.

Eligible dental expenses

- Copayments, coinsurance and deductible amounts.
- Preventive care.
- Exams, cleanings, X-rays, root canals and bridges.
- Dentures and fillings.

Eligible prescription drugs

- Copayments, coinsurance and deductible amounts;
- Cost for allowable prescription drugs.

Eligible non-prescription drugs and supplies

- Cost for certain allowable over-the-counter (OTC) medical supplies, materials, medicines and drugs.
- Cost for allowable menstrual care products. For purposes of this SPD, the term ‘menstrual care products’ means a tampon, pad, liner, cup, sponge, or similar products used by individuals with respect to menstruation or other genital-tract secretions.

Partial list of ineligible expenses

Examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).

- Expenses incurred before the effective date of your account.
- Certain over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your Health Care FSA cannot be claimed as deductions on your income tax return.

Limited Health Care Spending Account

Eligible health care expenses

To be eligible for reimbursement, the health care expenses must be all of the following:

- Incurred while you are participating in the Limited Health Care Spending Account.
- Incurred during the Plan year.

IMPORTANT NOTE: Any reimbursement you receive through your Limited Health Care Spending Account cannot be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement. Generally, eligible health care expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

A more comprehensive list of eligible expenses is available at myuhc.com. Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, IRS website irs.gov or by phone at 1-800-TAX-FORM (1-800-829-3676).

Eligible vision expenses

- Routine eye examinations.
- Eye glasses.
- Contact lenses, including all necessary supplies and equipment.

Eligible dental expenses

- Copayments, coinsurance and deductible amounts.
- Preventive care.
- Exams, cleanings, X-rays, root canals and bridges.
- Dentures and fillings.

Ineligible expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Insurance premiums, long term care premiums, and other payments or contributions for dental and vision coverage (such as contributions for coverage under an employer-sponsored group dental or vision plan or HMO or other dental or vision plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.

In addition, as with any other expense reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan, health expenses reimbursed through a Limited Health Care Spending Account cannot be claimed as deductions on your income tax return.

Eligible Dependent Care FSA expenses

Eligible dependent care expenses that can be reimbursed from your Dependent Care FSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a Dependent Care FSA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan year.

To qualify for reimbursement, dependent care expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent care expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13; or
- A spouse of a participant, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Eligible dependent care expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent care tax credit vs. Dependent Care FSA

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the Dependent Care FSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care FSA. In other words, you cannot use expenses reimbursed through the BEK Dependent Care FSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the Dependent Care FSA.

BEK Health Care Spending Card Debit MasterCard®

You will receive a Health Care Debit MasterCard® in the mail to use to pay for certain eligible expenses directly from your BEK Health Care or Dependent Care FSA. The card allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®. Use of the debit card is voluntary.

IMPORTANT NOTE: You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to myuhc.com to learn how to get the most out of your debit card.

You will automatically receive two debit cards in the mail at your home address. Read the terms and conditions found on the card insert and sign the back of your cards. You may call the customer service number listed on the back of your cards to order additional cards.

Activating your cards
If you choose to activate the debit cards, you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use with funds available real-time upon activation of the card within the first Plan year. However, for future Plan years, the funds will not be available for use until the effective date of the future Plan year.

If you decide not to activate the debit cards, simply destroy and discard both cards. You can be reimbursed for eligible expenses by completing a paper reimbursement form found on myuhc.com and as described in the *Requesting a reimbursement from your Flexible Spending Account* section of this chapter, or for eligible health care expenses by using the automatic reimbursement (auto-rollover) feature described in the *Automatic reimbursement (auto-rollover)* section of this chapter.

IMPORTANT NOTE: If you activate your card prior to the Plan effective date, you cannot use your card until the Plan effective date.

Qualified locations and providers
Your debit cards may be used at any approved provider or merchant with a point-of-service (POS) bankcard terminal that accepts MasterCard®. You can also enter the account number when making purchases online or on an order form, similar to using a credit card account. You can even use your card to pay for a bill you receive in the mail if the merchant or provider accepts MasterCard®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers, retail pharmacy counters, and child and adult day care facilities.

You may choose to use your debit card for mail order prescriptions or for eligible OTC medicines, supplies and materials by going to an online pharmacy. Additionally, your debit card can be used at Walgreen's retail stores or at participating retailers as described under the *Retailers with Inventory Information Approval System (IIAS)* section of this chapter.

Using your debit cards
In order to use your debit card, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from debit card purchases, because certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified health care or dependent care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe your debit card through the point-of-sale (POS) bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your FSA account based on the guidelines established by the IRS and your specific plan design as described in this chapter. A claim number will be assigned to the transaction.

Eligible expenses that are reimbursed when you use your card
Your card can be used for certain eligible dependent care expenses and eligible health care expenses including prescription copayments or out-of-pocket responsibility, eligible OTC medicines, supplies and materials, copayments at locations such as doctor, dentist, eye doctor, clinic, hospital or other care providers associated with medical, dental, vision at UnitedHealthcare in-network providers. Additionally, your card can be used for out-of-network copayments if your copayment is the same as the in-network copayment. Your card can only be used for copayments at medical physician locations, not for other patient financial responsibilities such as coinsurance and deductible. In this situation, please advise your physician to only process the copayment amount on your card, otherwise the transaction will be denied. Although coinsurance and deductibles are generally considered eligible FSA expenses, they are not valid card transactions. You will need to submit a claim form for reimbursement as described under the *Requesting a reimbursement from your Flexible Spending Account* section of this chapter.

IMPORTANT NOTE: You may be able to use your debit card to pay for an eligible expense under your Plan, including eligible OTC medicines, supplies and materials. Or you may purchase OTC medicines, supplies and materials using another form of payment, such as cash or a personal credit card. If it is an eligible expense under your Plan, you can manually submit for reimbursement.

Partial payment authorization
Partial authorization capability allows you to use your debit card with transactions amounts greater than the funds available in your health care FSA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your account, the account balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment.

IMPORTANT NOTE: Not all providers or merchants accept partial authorization.

Retailers with Inventory Information Approval System (IIAS)
IRS regulations require that retailers comply with IRS Inventory Information Approval System (IIAS) swipe technology as a method to identify and substantiate eligible health care expenses, per Section 213(d) of the Internal Revenue Code. The IIAS allows you to use your debit card to pay for 213(d) eligible health care expenses without having to provide any additional documentation or request reimbursement after a purchase is made, as transactions will be verified at the point of sale and payment will be made right from your HCSA. Additionally, IIAS compatibility allows you to use your debit card at participating retailers to pay for both ineligible expenses and eligible health care expenses on the same transaction with eligible health care expenses being approved via your debit card and remaining ineligible expenses may be paid using another form of payment. When you use your card at participating retailers, eligible health care expenses will be identified and noted on your receipt. You will not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your debit card. IRS guidelines still require you to save your itemized receipts as part of your tax records. You can see a full list of participating retailers at sig-is.org. If you go to a non-participating retailer, you can still buy eligible health care expenses that don't provide itemized sales receipts, however you will need to pay using another form of payment, and then submit receipts for reimbursement as described under the *Requesting a reimbursement from your FSA* section of this chapter.

Monthly health statements and FSA yearly statements
Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and an FSA yearly statement which will include your card activity. You will also be able to view card transactions on myuhc.com. If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your debit card to resolve the issue.

Go to myuhc.com or call 1-866-755-2648 toll-free to:
- Learn your account balance.
- Report a lost or stolen card.
- Order extra cards and more.

Requesting a reimbursement from your FSA

If you do not activate your debit card or choose not to use your card, you will need to submit a reimbursement form to the Claims Administrator, called a *Request for withdrawal*, for the eligible expenses that have been incurred. A *Request for withdrawal* form is available on myuhc.com. However, if the automatic reimbursement (auto-rollover) feature as described in the *Automatic reimbursement (auto-rollover)* section of this chapter is turned "on" you will not have to submit a reimbursement form for certain health care expenses.

For reimbursement from your BEK Health Care FSA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental/vision plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical, dental and vision plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental/vision plans are made.

For reimbursement from your BEK Dependent Care FSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification number of the care provider.

Only expenses which are incurred while you are a participant in the Plan or during the 2½ month period immediately following the end of the Plan year under the Dependent Care FSA may be reimbursed from an FSA. For the Dependent Care FSA, if your employment terminates you can continue to request reimbursement for eligible dependent care expenses incurred until the earlier of the date your account balance is exhausted or the end of the Plan year following your employment termination date against what is in your account balance at the time of termination. The dates of service must fall within the Plan year in which the Dependent Care FSA account termed. In addition, expenses which are incurred during one Plan year, with the exception of expenses incurred during the 2½ months immediately following the end of the Plan year under the Dependent Care FSA, cannot be reimbursed from funds contributed to the BEK Dependent Care FSA during another Plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form as often as every day. You will be reimbursed for eligible expenses as long as the amount requested from either account is at least $25, except for reimbursement with respect to the last month of the Plan year. Amounts below $25 will be accumulated and processed with future payments. However, if the automatic reimbursement (auto-rollover) feature as described in the *Automatic reimbursement (auto-rollover)* section of this chapter is turned "on" you will not have to submit a reimbursement form for certain health care expenses.

If you have established a health care FSA, your total annual contribution is available immediately. You can request reimbursement for eligible expenses up to your annual contribution amount as soon as such eligible expenses have been incurred.

If you have established a Dependent Care FSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

Requests for withdrawal will be accepted and processed through March 31st of the following year for expenses incurred during the Plan year and during the 2½ months immediately following the end of the Plan year under the BEK Dependent Care FSA. If your employment terminates you can continue to request reimbursement for eligible dependent care expenses incurred until the earlier of the date your account balance is exhausted or the end of the Plan year following your employment termination date against what is in your account balance at the time of termination. The dates of service must fall within the Plan year in which the dependent care account termed. Any such eligible dependent care expenses must be submitted on or before March 31st of the Plan year following your termination.

In accordance with IRS regulations, amounts contributed to your BEK Dependent Care FSA during the Plan year that remain in your account at the end of the processing period (March 31st of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited.

myuhc.com features include:

- View Explanation of Benefits/health statements.
- Utilize a savings calculator.
- View your FSA summary page detailing contributions and amount left in your FSA account.
- View your FSA claims summary, including claim transaction details.

Automatic reimbursement for the BEK Health Care FSA

You can elect to have eligible expenses for claims which are not covered under your UnitedHealthcare-administered medical plans automatically submitted for reimbursement. This eliminates extra paperwork and makes it more convenient for you to use your FSAs. You can turn auto-rollover of claims “off” or back “on” at myuhc.com. All claims must still be verified, and UnitedHealthcare may request additional documentation that proves your claim.

However, if you have medical, dental and/or vision coverage administered through another carrier, the automatic reimbursement (auto-rollover) feature does not apply. Further, the automatic reimbursement (auto-rollover) feature does not apply to any applicable domestic partner covered under an employer's group health plan, unless the applicable domestic partner is a federal tax dependent for health coverage purposes, as defined under Section 105(b) of the IRS Code. An FSA withdrawal request must be submitted for any other types of expenses such as dependent care expenses and any health expenses not submitted to your health benefits carrier.

IMPORTANT NOTE: For the Limited Health Care Spending Account (LHCSA) and dependent care FSA you will most likely need to submit a reimbursement form to the Claims Administrator, called a *Request for withdrawal*, for the eligible expenses that have been incurred. Automatic reimbursement will not be available.

Extension for expenses incurred in the BEK Dependent Care FSA
If you have unused contributions in your account at the end of the current Plan year, you can continue to incur expenses during the first 2½ months in the BEK Dependent Care FSA immediately following the end of the Plan year and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through March 31st. After March 31st, funds remaining in your account for the current Plan year will be forfeited. Unused benefits relating to a particular qualified benefit may only be used to pay expenses incurred with respect to that particular benefit and cannot be transferred to another account.

If you elect FSA coverage for the next Plan year and there are still funds available in your account from the current Plan year, expenses incurred between the end of the current Plan year and March 15th of the next Plan year will be reimbursed from the funds in your current Plan year's account until they are depleted.

If you enroll in a Health Savings Account (HSA) at the end of the Plan year, you will not be eligible to make any HSA contributions before March 15th in the BEK Dependent Care FSA unless you have used all of the funds in your account from the current Plan year.

Claims denials and appeals procedures

If your claim is denied
If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your FSA debit card or your Medical ID card before requesting a formal appeal. UnitedHealthcare will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

How to appeal a denied claim
If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on your Medical ID card.
- The provider's name.
- The date of medical service.
- The reason you think your claim should be paid.
- Any documentation or other written information to support your request.

You or your dependent may send a written request for an appeal to:

UnitedHealthcare – Appeals
Attn Appeals
P.O. Box 981512
El Paso, TX 79998-1512

Review of an appeal
UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination; and
- A health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a second appeal
Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal. Ben E. Keith Company must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Ben E. Keith Company will review all claims in accordance with the rules established by the U.S. Department of Labor. Ben E. Keith Company's decision will be final.

The following chart describes the time frames related to claims which you and UnitedHealthcare are required to follow.

Type of claims denials and appeals	Timing
If your claim is incomplete, UnitedHealthcare must notify you…	Within 30 days
You must then provide completed claim information to UnitedHealthcare…	Within 45 days after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
– If the initial claim is complete…	Within 30 days
– After receiving the completed claim (if the initial claim is incomplete) …	Within 30 days
You must appeal the claim denial…	No later than 180 days after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision…	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal)…	Within 60 days after receiving the first level appeal decision
Ben E. Keith Company must notify you of the second level appeal decision…	30 days after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

When participation ends

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date your employment with the Company ends.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.
- The date you retire, unless the Plan is available for retired persons and you are eligible.

Health Care Spending Account and Limited Health Care Spending Account
You may submit a claim for reimbursement of eligible expenses which were incurred during the Plan year of employment termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before March 31st of the next Plan year.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Limited Health Care Spending Account Plan. You should call UnitedHealthcare to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA, review the COBRA notice in the **Plan administration and ERISA rights** chapter.

Claims Administrator
UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

If you have questions about your FSA debit card transactions, call the number on back of your card. For claims questions, contact UnitedHealthcare by phone at the number on your Medical ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

BEK Dental Plan

Eligibility

Participation in the Ben E. Keith Dental Plan is open to eligible employees and their dependents. The eligibility rules for Plan participation can be found in the **Eligibility and enrollment** chapter, which also describes:

- When Plan participation begins.
- Cost of coverage.
- How to enroll.
- Changing your coverage during the year.
- When Plan participation ends.

Enrollment

Individuals who enroll themselves and their eligible dependents after their initial enrollment period are considered *late entrants*. You may not enroll until the next Annual Enrollment period unless you have a qualified life event as described in the **Eligibility and enrollment** chapter.

Important information about your dental Plan

When you elected dental insurance for yourself and your dependents, you elected one of the two options offered:

- Cigna Dental Care.
- Cigna Dental Choice.

Details of the benefits under each of the options are described in the following pages. When electing an option initially or when changing options as described below, the following rules apply:

- You and your dependents may enroll for only one of the options, not for both options.
- Your dependents will be insured only if you are insured and only for the same option.

Change in option elected

If your Plan is subject to Section 125 (an IRS regulation), you are allowed to change options only at open enrollment or when you experience a qualified life event as described in the **Eligibility and enrollment** chapter. If your Plan is not subject to Section 125, you are allowed to change options at any time. Consult your Plan Administrator for the rules that govern your Plan.

Effective date of change

If you change options during open enrollment, you (and your dependents) will become insured on the effective date of the plan. If you change options other than at open enrollment (as allowed by your plan), you will become insured on the first day of the month after the transfer is processed.

Cigna Dental Care: choice of dental office

If you elect Cigna Dental Care you must select a network general dentist and an alternate provider from a list provided by CDH. CDH will notify you if your first choice of provider is not available and you will be assigned to the alternate provider. Each insured family member may select their own network general dentist.

Dental coverage only applies if:

- The dental service is received from your network general dentist; or
- Your network general dentist refers you to a specialist approved by CDH; or
- The service is otherwise authorized by CDH; or
- The service is emergency treatment as specified in your certificate.

A transfer to a different network general dentist takes effect on the first day of the month after it is authorized by CDH.

How to file your claim

Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

Claim reminders

- Be sure to use your Member ID and account/group number when you file Cigna's claim forms, or when you call your Cigna claim office.
- Your Member ID is the id shown on your benefit identification card.
- Your account/group number is shown on your benefit identification card.
- Be sure to follow the instructions listed on the back of the claim form carefully when submitting a claim to Cigna.

Timely filing

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year, the claim will not be considered valid and will be denied.

Note: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

BEK PPO Dental Plan (Cigna Dental Choice Plan)

Deductibles

Deductibles are expenses to be paid by you or your dependent. Deductibles are in addition to any coinsurance. Once the deductible maximum in the *Schedule of Benefits* has been reached, you and your family need not satisfy any further dental deductible for the rest of that year.

Benefit payment

Services of a contracted dentist are paid based on the contracted fee agreed upon by the provider and the insurance company. Services of a non-contracted dentist are based on the maximum reimbursable charge. For this plan, the maximum reimbursable charge is calculated at the 90th percentile of all provider charges in the geographic area.

Schedule of Benefits

	BEK PPO Dental Plan
Classes I, II, III, IX calendar year benefit maximum per member	$2,000
Annual deductible – individual / family	$50 / $150
Class I Preventive care – oral exams, cleanings, x-rays, fluoride treatments	$0
Class II Basic services – fillings, extractions, emergency exams, Periodontics, Endodontics	20% after deductible
Class III Major procedures – crowns, inlays/onlays, dentures and bridgework, oral surgery, prosthodontic maintenance	50% after deductible
Class IV Orthodontia – for adults and children up to age 26	50% after deductible
Class IV Lifetime orthodontia maximum per member	$2,000
Implants	50% after deductible

Covered dental expense

Covered dental expense means that portion of a dentist's charge that is payable for a service delivered to a covered person provided:

- The service is ordered or prescribed by a dentist.
- The service is essential for the necessary care of teeth.
- The service is within the scope of coverage limitations.
- The deductible amount in the *Schedule of Benefits* has been met.
- The maximum benefit in the *Schedule of Benefits* has not been exceeded.
- The charge does not exceed the amount allowed under the *Alternate benefit provision*.
- For Class I, II or III expenses the service is started and completed while coverage is in effect, except for services described in the *Benefits extension* section.

Alternate benefit provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends *Predetermination of benefits* before major treatment begins

Predetermination of benefits

Predetermination of benefits is a voluntary review of a dentist’s proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative X-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no predetermination of benefits, Cigna will determine covered dental expenses when it receives a claim. Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $200.

Predetermination of benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered, the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

Texas statutory provision

General anesthesia and I.V. sedation services for certain persons. Covered dental expenses include: coverage for medically or dentally necessary general anesthesia and I.V. sedation services when performed in a dental office in conjunction with any covered dental procedure, if the individual is unable to undergo dental treatment in a normal office setting or under local anesthesia, and to the extent that the claim is also submitted for payment to any applicable medical carrier for Coordination of Benefits.

Cigna Dental Choice. Plan payment for a covered service delivered by a contracted provider is the contracted fee for that procedure, times the benefit percentage that applies to the class of service, as specified in the *Schedule of Benefits*.

The covered person is responsible for the balance of the contracted fee.

Plan payment for a covered service delivered by a non-contracted provider is the maximum reimbursable charge for that procedure, times the benefit percentage that applies to the class of service, as specified in the *Schedule of Benefits*. The covered person is responsible for the balance of the non-contracted provider’s actual charge.

Class I services – diagnostic and preventive

- Clinical oral examination – only 2 per person per calendar year.
- X-rays – complete series or panoramic (Panorex) – only one per person, including panoramic film, in any 36 consecutive months.
- Bitewing X-rays – only 2 charges per person per calendar year.
- Prophylaxis (cleaning), including periodontal maintenance procedures (following active therapy) – only 2 per person per calendar year.
- Topical application of fluoride (excluding prophylaxis) – limited to persons less than 19 years old – only 2 per person per calendar year.
- Topical application of sealant, per tooth, on a posterior tooth for a person less than 16 years old – only 1 treatment per tooth in any 3 calendar years.
- Space maintainers, fixed unilateral – limited to non-orthodontic treatment.

Class II services – basic restorations, periodontics, endodontics

- Amalgam filling composite/resin filling.
- Root canal therapy – any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service.
- Osseous surgery – flap entry and closure is part of the allowance for osseous surgery and not a separate dental service.
- Periodontal scaling and root planing – entire mouth routine extractions.
- Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures – are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
- General anesthesia – paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this Plan.
- I.V. sedation – paid as a separate benefit only when medically or dentally necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this Plan.
- Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive dental services are performed. (Any x-ray taken in connection with such treatment is a separate dental service.)

Class III services – major restorations, dentures and bridgework, oral surgery, prosthodontic maintenance

- Crowns. **Important note:** Crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
  - Porcelain fused to high noble metal.
  - Full cast, high noble metal.
  - Three-fourths cast, metallic.
- Removable appliances.
  - Complete (full) dentures, upper or lower.
  - Partial dentures.
  - Lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth).
  - Upper, cast metal base with resin saddles (including any conventional clasps rests and teeth).
- Fixed Appliances
  - Bridge pontics – cast high noble metal.
  - Bridge pontics – porcelain fused to high noble metal.
  - Bridge pontics – resin with high noble metal.
  - Retainer crowns - resin with high noble metal.
  - Retainer crowns - porcelain fused to high noble metal.
  - Retainer crowns - full cast high noble metal.
- Prosthesis over implant – A prosthetic device, supported by an implant or implant abutment is a covered expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.

- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
  - Removal of impacted tooth, soft tissue.
  - Removal of impacted tooth, partially bony.
  - Removal of impacted tooth, completely bony.
- Adjustments – complete denture.
  - Any adjustment of or repair to a denture within 6 months of its installation is not a separate dental service.
- Re-cement Bridge.

Class IV services – orthodontics
Each month of active treatment is a separate dental service.

Covered expenses include:
- Orthodontic work-up including X-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or removable appliances – only one appliance per person for tooth guidance or to control harmful habits.
- Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum shown in the *Schedule of Benefits*.

Payments for comprehensive full-banded orthodontic treatment are made in installments. Benefit payments will be made every three (3) months. The first payment is due when the appliance is installed. Later payments are due at the end of each three-month period. The first installment is 25% of the charge for the entire course of treatment. The remainder of the charge is prorated over the estimated duration of treatment. Payments are only made for services provided while a person is insured. If insurance coverage ends or treatment ceases, payment for the last three-month period will be prorated.

Class IX services – implants
Covered dental expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

Implant coverage may have a separate deductible amount, yearly maximum and/or lifetime maximum as shown in the *Schedule of Benefits*.

Expenses not covered
Covered expenses will not include, and no payment will be made for:
- Services performed solely for cosmetic reasons, except for the treatment of congenital defects in a newborn child.
- Replacement of a lost or stolen appliance.
- Replacement of a bridge, crown or denture within five (5) years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion.
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- Bite registrations; precision or semi-precision attachments; or splinting.
- Instruction for plaque control, oral hygiene and diet.
- Dental services that do not meet common dental standards.

- Services that are deemed to be medical services.
- Services and supplies received from a hospital.
- Services for which benefits are not payable according to the *General limitations* section of this chapter.

General limitations

Dental benefits

No payment will be made for expenses incurred for you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- For or in connection with a sickness which is covered under any workers' compensation or similar law.
- For charges made by a hospital owned or operated by or which provides care or performs services for, the United States government, if such charges are directly related to a military-service-connected condition.
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- To the extent that billed charges exceed the rate of reimbursement as described in the Schedule of Benefits.
- For charges for unnecessary care, treatment or surgery.
- To the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

Coordination of Benefits (COB)

The Coordination of Benefits provision applies when a person has health care coverage under more than one plan. Plan is defined in the *Definitions* section below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

A. A “plan” is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.
2. Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers’ compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a “24-hour” or a “to and from school” basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without

regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under A.1. or A.2. is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

C. “Allowable expense” is a health care expense, including deductibles, Coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
4. If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

D. “Allowed amount” is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier’s payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

E. "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

F. "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order of benefit determination rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

B. Except as provided in C. a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

C. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

D. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

E. If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

F. When multiple contracts providing coordinated coverage are treated as a single plan under the **Order of benefit determination rules** in the *Coordination of benefits* section of this **Dental** chapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with the **Order of benefit determination rules** in the *Coordination of benefits* section of this **Dental** chapter.

G. If a person is covered by more than one secondary plan, the order of benefit determination rules of the **Order of benefit determination rules** in the *Coordination of benefits* section of this **Dental** chapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

H. Each plan determines its order of benefits using the first of the following rules that apply.

1. Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policy holder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

2. Dependent child covered under more than one plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

i. If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Plan years commencing after the plan is given notice of the court decree.
ii. If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of H.2.a) must determine the order of benefits.
iii. If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of H.2.a) must determine the order of benefits.
iv. If there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    a. The plan covering the custodial parent;
    b. The plan covering the spouse of the custodial parent;
    c. The plan covering the noncustodial parent; then
    d. The plan covering the spouse of the noncustodial parent.

c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of- network benefits.
d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.
f) When multiple contracts providing coordinated coverage are treated as a single plan under this *Order of benefit determination rules* in the *Coordination of benefits* section of this chapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this *Order of benefit determination rules* in the *Coordination of benefits* section of this chapter.
g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this *Order of benefit determination rules* in the *Coordination of benefits* section of this chapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.
h) Each plan determines its order of benefits using the first of the following rules that apply.
    i. Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.
    ii. Dependent child covered under more than one plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.
        a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
            i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
            ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b. For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

i. If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Plan years commencing after the plan is given notice of the court decree.

ii. If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of h) ii.a. must determine the order of benefits.

iii. If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of h) ii.a. must determine the order of benefits.

iv. If there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

I. The plan covering the custodial parent;

II. The plan covering the spouse of the custodial parent;

III. The plan covering the noncustodial parent; then

IV. The plan covering the spouse of the noncustodial parent.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of h) ii.a. or h) ii.b. must determine the order of benefits as if those individuals were the parents of the child.

d. For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, h) iv. applies.

e. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in h) ii.a. to the dependent child's parent(s) and the dependent's spouse.

iii. Active, retired, or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if h) i. can determine the order of benefits.

iv. COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if h) i. can determine the order of benefits.

v. Longer or shorter length of coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

vi. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Effect on the benefits of this plan

a. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total

benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Cigna will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. Each person claiming benefits under this Plan must give Cigna any facts it needs to apply those rules and determine benefits.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does Cigna may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Cigna will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by Cigna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Expenses for which a third party may be responsible

This Plan does not cover:

- Expenses incurred by you or your dependent; (hereinafter individually and collectively referred to as a "participant,") for which another party may be responsible as a result of having caused or contributed to an injury or sickness.
- Expenses incurred by a participant to the extent any payment is received for them either directly or indirectly from a third-party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Right of reimbursement

If a participant incurs a covered expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Lien of the Plan

By accepting benefits under this Plan, a participant:

- Grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the participant which is binding on any attorney or other party who represents the participant whether or not an agent of the participant or of any insurance company or other financially responsible party against whom a participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents.
- Agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon.
- Agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan.

Additional terms

- No adult participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor dependent of said adult participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine."
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any participant, whether under comparative negligence or otherwise.
- In the event that a participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Payment of Benefits

To whom payable

Dental benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, in certain limited circumstances, make payment to you for the cost of any covered expenses from a non-participating provider even if benefits have been assigned. You may assign the right of payment or reimbursement to the dentist who provides the dental care services. We may pay benefits to you directly in certain rare circumstances. Such circumstances may include if the provider is deceased, if the provider is located in a foreign country or if you have already paid the provider. When benefits are paid to you or your dependent, you or your dependent is responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of overpayment
When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment to the dentist who provided the service.

Miscellaneous

Clinical research has established an association between dental disease and complication of some medical conditions, such as the conditions noted below.

If you are a Cigna Dental Plan member and you have one or more of the conditions listed below, you may apply for 100% reimbursement of your copayment or coinsurance for certain periodontal or caries-protection procedures (up to the applicable Plan maximum reimbursement levels and annual Plan maximums.)

For members with diabetes, cerebrovascular or cardiovascular disease:
- Periodontal scaling and root planing (sometimes referred to as “deep cleaning”).
- Periodontal maintenance.

For members who are pregnant:
- Periodic, limited and comprehensive oral evaluation.
- Periodontal evaluation.
- Periodontal maintenance.
- Periodontal scaling and root planing (sometimes referred to as “deep cleaning”).
- Treatment of inflamed gums around wisdom teeth.
- An additional cleaning during pregnancy.
- Palliative (emergency) treatment – minor procedure.

For members with chronic kidney disease or going to or having undergone an organ transplant or undergoing head and neck cancer radiation:
- Topical application of fluoride.
- Topical fluoride varnish.
- Application of sealant.
- Periodontal scaling and root planing (sometimes referred to as “deep cleaning”).
- Periodontal maintenance.

Please refer to the Plan enrollment materials for further details.

Termination of insurance

Employees
Your insurance will cease on the earliest date below:
- The date you cease to be in a class of eligible employees or cease to qualify for the insurance.
- The last day for which you have made any required contribution for the insurance.
- The date the policy is canceled.
- The last day of the calendar month in which your active service ends except as described below.
- Any continuation of insurance must be based on a plan which precludes individual selection.

Injury or sickness
If your active service ends due to an injury or sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the injury or sickness. However, your insurance will not continue past the date your employer stops paying premium for you or otherwise cancels your insurance.

Dependents
Your insurance for all of your dependents will cease on the earliest date below:
- The date your insurance ceases.
- The date you cease to be eligible for dependent insurance.

- The last day for which you have made any required contribution for the insurance.
- The date dependent insurance is canceled.

The insurance for any one of your dependents will cease on the date that dependent no longer qualifies as a dependent.

Dental benefits extension

An expense incurred in connection with a dental service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- For a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within three (3) calendar months after his insurance ceases.
- For root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within three (3) calendar months after his insurance ceases.

There is no extension for any dental service not shown above.

Notice of an appeal or a grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

The following will apply to residents of Texas

When you have a complaint or an adverse determination appeal

For the purposes of this section, any reference to "you," "your" or "member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

When you have a complaint

We are here to listen and help. If you have a complaint regarding a person, a service, the quality of care, or contractual benefits not related to medical necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination. You can also express that complaint in writing. Please call or write to us using the Customer Service toll-free number or address that appears on your Member ID card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your complaint, we will send you a letter acknowledging the date on which we received your complaint no later than the fifth working day after we receive your complaint. We will respond in writing with a decision 30 calendar days after we receive a complaint for a post-service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

If you are not satisfied with the results of a coverage decision, you can start the complaint appeals procedure.

Complaint appeals procedure

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Member ID card, explanation of benefits or claim form.

Your complaint appeal request will be conducted by the complaint appeals committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the committee. You may present your situation to the committee in person or by conference call.

We will acknowledge in writing that we have received your request within five working days after the date we receive your request for a committee review and schedule a committee review. The committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the committee to complete the review. You will be notified in writing of the committee's decision within five working days after the committee meeting, and within the committee review time frames above if the committee does not approve the requested coverage.

When you have an adverse determination appeal
An adverse determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to you is (are) not medically necessary or clinically appropriate. An adverse determination also includes a denial by Cigna of a request to cover a specific prescription drug prescribed by your dentist. If you are not satisfied with the adverse determination, you may appeal the adverse determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the adverse determination appeal request.

Your appeal of an adverse determination will be reviewed and the decision made by a health care professional not involved in the initial decision. We will respond in writing with a decision within 30 calendar days after receiving the adverse determination appeal request.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the dental Plan will respond orally with a decision within 72 hours, but will not exceed one working day from the date all information necessary to complete the appeal is received followed up in writing.

In addition, your treating dentist may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a dentist in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an independent review organization.

Retrospective review requirements
Notice of adverse determinations (denials only) of retrospective reviews must be made in writing to the patient within a reasonable period, not to exceed 30 days from the date of receipt.

The term retrospective review is a system in which review of the medical necessity and appropriateness of health care services provided to an enrollee is performed for the first time subsequent to the completion of such health care services. Retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

Independent review procedure
If you are not fully satisfied with the decision of Cigna's adverse determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an independent review organization. In addition, your treating dentist may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the adverse determination appeal decision letter. Cigna must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial adverse determination, you are still eligible to request a review by an independent review organization. The independent review organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the Plan.

There is no charge for you to initiate this independent review process and the decision to use the process is voluntary. Cigna will abide by the decision of the independent review organization.

In order to request a referral to an independent review organization, certain conditions apply. The reason for the denial must be based on a medical necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an independent review and the required forms you will need to complete with every adverse determination notice.

The independent review program is a voluntary program arranged by Cigna.

Appeal to the State of Texas
You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an adverse determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

333 Guadalupe Street
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

Notice of benefit determination on appeal
Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the denial decision; reference to the specific Plan provisions on which the decision is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information as defined; a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant information
Relevant information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal action under federal law
If your Plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the complaint or adverse determination appeal process. If your complaint is expedited, there is no need to complete the complaint appeal process prior to bringing legal action.

BEK DHMO Dental Plan for Texas residents only

Introduction to your Cigna Dental Plan

Welcome to the Cigna Dental Plan. We encourage you to use your dental benefits. Please note that enrollment in the dental Plan allows the release of patient records to Cigna Dental or its designee for health plan operation purposes. For more information or to find a Cigna Dental Health network dentist, visit myCigna.com.

Eligibility

Participation in the Ben E. Keith DHMO Dental Plan is open to eligible employees and their dependents. The eligibility rules for Plan participation can be found in the **Eligibility and enrollment** chapter, which also describes:

- When Plan participation begins.
- Cost of coverage.
- How to enroll.
- Changing your coverage during the year.
- When Plan participation ends.

To enroll in this Plan, you and your dependents must live, work or reside within the Cigna Dental service area. Other eligibility requirements are determined by your group. For a list of Cigna Dental Health Texas service areas, visit myCigna.com.

If the legal residence of an enrolled dependent is different from that of the subscriber, the dependent must:

A. Reside in the service area with a person who has temporary or permanent guardianship, including adoptees or children subject to adoption, and the subscriber must have legal responsibility for that dependent's health care; or

B. Reside in the service area, and the subscriber must have legal responsibility for that dependent's health care; or

C. Reside in the service area with the subscriber's spouse; or

D. Reside anywhere in the United States when the dependent's coverage is required by a medical or dental support order.

If you or your dependent becomes eligible for Medicare, you may continue coverage so long as you or your Medicare-eligible dependent meet all other group eligibility requirements.

If you enrolled in the dental Plan before the effective date of your Group Contract, you will be covered on the first day the group contract is effective. If you enrolled in the dental Plan after the effective date of the group contract, you will be covered on the first day of the month following processing of your enrollment (unless effective dates other than the first day of the month are provided for in your group contract).

Dependents may be enrolled in the dental Plan at the time you enroll, during an open enrollment, or within 31 days of becoming eligible due to a qualified life event such as marriage, birth, adoption, placement, or court or administrative order. You may drop coverage for your dependents only during the open enrollment periods for your group, unless there is a change in status such as divorce. Cigna Dental may require evidence of good dental health at your expense if you or your dependents enroll after the first period of eligibility (except during open enrollment) or after disenrollment because of nonpayment of premiums.

If you have family coverage, a newborn child is automatically covered during the first 31 days of life. If you wish to continue coverage beyond the first 31 days, your baby must be enrolled in the dental Plan and you must begin paying premiums, if any additional are due, during that period.

Under the Family and Medical Leave Act of 1993, you may be eligible to continue coverage during certain leaves of absence from work. During such leaves, you will be responsible for paying your group the portion of the premiums, if any, which you would have paid if you had not taken the leave. Additional information is available through Lincoln Financial Group.

Your Cigna Dental coverage

The information below outlines your coverage and will help you to better understand your dental Plan. Included is information about which services are covered, which are not, and how much dental services will cost you. A copy of the group contract will be furnished to you upon your request.

A. Customer service. If you have any questions or concerns about the dental Plan, call a Cigna Customer Service representative at 1-800-Cigna24. They can explain your benefits or help with matters regarding your dental office or dental Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, covered services, Plan benefits, Member ID cards, location of dental offices, conversion coverage or other matters.

The hearing impaired may contact Customer Service through the State Relay Service located in your local telephone directory.

B. Premiums. Your group sends a monthly fee to Cigna Dental for customers participating in the dental Plan. The amount and term of this fee is set forth in your group contract. Contact your HR Manager or Office Manager for information regarding any part of this fee to be withheld from your salary or to be paid by you to the group. Your premium is subject to annual change in accordance with your group contract. Cigna Dental will give written notice to your group of any change in premiums at least 60 days before any change.

In addition to any other premiums for which the group is liable, the group shall also be liable for a customer's premiums from the time the customer is no longer eligible for coverage under the contract until the end of the month in which the group notifies Cigna Dental that the customer is no longer part of the group eligible for coverage.

C. Other charges – patient charges. Cigna Dental typically pays network general dentists fixed monthly payments for each covered customer and supplemental payments for certain procedures. No bonuses or financial incentives are used as an inducement to limit services. Network dentists are also compensated by the fees that you pay, as set out in your *Patient Charge Schedule*, which is available on myCigna.com.

Your *Patient Charge Schedule* lists the dental procedures covered under your dental Plan. Some dental procedures are covered at no charge to you. For other covered services, the *Patient Charge Schedule* lists the fees you must pay when you visit your dental office. There are no deductibles and no annual dollar limits for services covered by your dental Plan.

Your network general dentist should tell you about patient charges for covered services the amount you must pay for non-covered services and the dental office's payment policies. Timely payment is important. The dental office may add late charges to overdue balances.

Your *Patient Charge Schedule* is subject to annual change in accordance with your group contract. Cigna Dental will give written notice to your group of any change in patient charges at least 60 days prior to such change. You must pay the patient charge listed on the *Patient Charge Schedule* that is in effect on the date a procedure is started.

D. Choice of dentist. You and your dependents should have selected a dental office when you enrolled in the dental Plan. If you did not, you must advise Cigna Dental of your dental office selection prior to receiving treatment. The benefits of the dental Plan are available only at your dental office, except in the case of an emergency or when Cigna Dental otherwise approves payment for out-of-network benefits.

You may select a network Pediatric dentist as the network general dentist for your dependent children under age 13 by calling Customer Service at 1-800-Cigna24 to get a list of network pediatric dentists in your service area or if your network general dentist sends your child under the age of 13 to a network pediatric dentist, the network pediatric dentist's office will have primary responsibility for your child's care. For children 13 years and older, your network general dentist will provide care. If your child continues to visit the pediatric dentist upon the age of 13, you will be fully responsible for the pediatric dentist's usual fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected dental office cannot provide your dental care, or if your network general dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another dental office. Refer to the section titled *Office transfers* if you wish to change your dental office.

To obtain a list of dental offices near you, visit myCigna.com, or call the dental office locator at 1-800-Cigna24. It is available 24 hours a day, 7 days a week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current dental office directory by calling Customer Service.

E. Your payment responsibility (general care). For covered services at your dental office, you will be charged the fees listed on your *Patient Charge Schedule*. For services listed on your *Patient Charge Schedule* at any other dental office, you may be charged usual fees. For non-covered services, you are responsible for paying usual fees.

If on a temporary basis there is no network general dentist in your service area, Cigna Dental will let you know and you may obtain covered services from a non-network dentist. Cigna Dental will approve a referral to a non-network dentist within 5 business days. You will pay the non-network dentist the applicable patient charge for covered services. Cigna Dental will pay the non-network dentist the difference, if any, between his or her usual fee and the applicable patient charge.

See the *Specialty referrals* section of this **Dental** chapter regarding payment responsibility for specialty care.

All contracts between Cigna Dental and network dentists state that you will not be liable to the network dentist for any sums owed to the network dentist by Cigna Dental.

F. General care – reimbursement. Cigna Dental Health will acknowledge your claim for covered services within 15 days and accept, deny, or request additional information within 15 business days of receipt. If Cigna Dental Health accepts your claim, reimbursement for all appropriate covered services will be made within 5 days of acceptance.

G. Emergency dental care – reimbursement. Emergency dental services are limited to procedures administered in a dental office, dental clinic or other comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson with average knowledge of dentistry to believe that immediate care is needed.

1. Emergency care away from home - If you have an emergency while you are out of your service area or unable to contact your network general dentist, you may receive emergency covered services as defined above without restrictions as to where the services are rendered. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your network general dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your *Patient Charge Schedule*. Cigna Dental will reimburse you the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge.

To receive reimbursement, send appropriate reports and X-rays to Cigna. Cigna Dental Health will acknowledge your claim for emergency services within 15 days and accept, deny, or request additional information within 15 business days of receipt. If Cigna Dental Health accepts your claim, reimbursement for all appropriate emergency services will be made within 5 days of acceptance. Claims for non-emergency services will be processed within the same timeframes as claims for emergency services.

H. Limitations on covered services. Listed below are limitations on services when covered by your dental Plan.

- Frequency – The frequency of certain covered services, like cleanings, is limited. Your *Patient Charge Schedule* lists any limitations on frequency. If your network general dentist certifies to Cigna Dental that, due to medical necessity, you require certain covered services more frequently than the limitation allows, Cigna Dental may waive the applicable limitation.
- Pediatric dentistry – Coverage for treatment by a pediatric dentist ends on your child's 13th birthday. Effective on your child's 13th birthday, dental services must be obtained from a network general dentist; however, exceptions for medical reasons may be considered on an individual basis.
- Oral surgery – The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your *Patient Charge Schedule* lists any limitations on oral surgery.
- Periodontal (gum tissue and supporting bone) Services – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the *Patient Charge Schedule*.
- Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the *Patient Charge Schedule*.
- Clinical oral evaluations – When this limitation is noted on the *Patient Charge Schedule*, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- Surgical placement of implant services – When covered on the *Patient Charge Schedule*, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- Prosthesis over implant – When covered on the *Patient Charge Schedule*, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

General limitations of dental benefits

No payment will be made for expenses incurred or services received:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- For charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance.
- To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received.
- For the charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- Due to injuries which are intentionally self-inflicted.

I. **Services not covered under your dental Plan**. Listed below are the services or expenses which are NOT covered under your dental Plan and which are your responsibility at the dentist's usual fees. There is no coverage for:

- Services not listed on the *Patient Charge Schedule*.
- Services provided by a non-network dentist without Cigna Dental's prior approval (except emergencies, as described in the previous *Emergency dental care – reimbursement* section).
- Services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your *Patient Charge Schedule*. If bleaching (tooth whitening) is listed on your *Patient Charge Schedule*, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your *Patient Charge Schedule*. When listed on your *Patient Charge Schedule*, general anesthesia and I.V. sedation are covered when medically necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
- Prescription medications.
- Procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when the teeth are in contact); restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
- Surgical placement of a dental implant, repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your *Patient Charge Schedule*.
- Services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- Procedures or appliances for minor tooth guidance or to control harmful habits.

- Hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for network dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
- Services to the extent you or your enrolled dependent are compensated under any group medical plan, no-fault auto insurance policy, or uninsured motorist policy.
- Crowns, bridges and/or implant supported prosthesis used solely for splinting.
- Resin bonded retainers and associated pontics.
- Consultations and/or evaluations associated with services that are not covered.
- Endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless prognosis.
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction unless specifically listed on your *Patient Charge Schedule*.
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.
- Intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.
- Services performed by a prosthodontist.
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service.
- Infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.
- The recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within the timeframe to be incidental to and part of the charges for the initial restoration.
- The recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within the timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your *Patient Charge Schedule*.
- Services to correct congenital malformations, including the replacement of congenitally missing teeth.
- The replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on your *Patient Charge Schedule*.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your *Patient Charge Schedule*. Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

Appointments
To make an appointment with your network dentist, call the dental office that you have selected. When you call, your dental office will ask for your Member ID number and will check your eligibility.

Broken appointments
The time your network dentist schedules for your appointment is valuable to you and the dentist. If you must change your appointment, please contact your dentist at least 24 hours before the scheduled time.

Office transfers
If you decide to change dental offices, we can arrange a transfer at no charge. You should complete any dental procedure in progress before transferring to another dental office. To arrange a transfer, call Customer Service at 1-800- Cigna24. To obtain a list of dental offices near you, visit myCigna.com, or call the dental office locator at 1-800-Cigna24.

Your transfer may take up to 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new dental office until your transfer becomes effective. You can check the status of your request by visiting myCigna.com, or by calling us at 1-800-Cigna24.

Network dentists are independent contractors. Cigna Dental cannot require that you pay your patient charges before processing of your transfer request; however, it is suggested that all patient charges owed to your current dental office be paid prior to transfer.

Specialty care

Your network general dentist at your dental office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental network includes the following types of specialty dentists:

- Pediatric dentists – children's dentistry.
- Endodontists – root canal treatment.
- Periodontists – treatment of gums and bone.
- Oral surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

There is no coverage for referrals to prosthodontists or other specialty dentists not listed above.

When specialty care is needed, your network general dentist must start the referral process. X-rays taken by your network general dentist should be sent to the network specialty dentist.

You and your dependents may not be covered twice under this dental Plan. If you and your spouse have enrolled each other or the same dependents twice, please contact the Benefits Team.

See *D. Choice of dentist* in the *Your Cigna Dental coverage* section regarding treatment by a pediatric dentist.

Specialty referrals

A. In general. Preauthorization is not required for coverage of services by a network specialty dentist.

When Cigna Dental approves payment to the network specialty dentist, the fees or no-charge services listed on the *Patient Charge Schedule* in effect on the date each procedure is started will apply, except as set out in section *B. Orthodontics* below. Treatment by the network specialty dentist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90-day period, please call Customer Service to request an extension. Your coverage must be in effect when each procedure begins.

For non-covered services or if Cigna Dental does not approve payment to the network specialty dentist for covered services, including adverse determinations, you must pay the network specialty dentist's usual fee. If you have a question or concern regarding an approval or a denial, contact Customer Service.

After the network specialty dentist has completed treatment, you should return to your network general dentist for cleanings, regular checkups and other treatment. If you visit a network specialty dentist without a referral or if you continue to see a network specialty dentist after you have completed specialty care, you must pay for treatment at the dentist's usual fees.

When your network general dentist determines that you need specialty care and a network specialty dentist is not available, as determined by Cigna Dental, Cigna Dental will approve a referral to a non-network specialty dentist within 5 business days. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable patient charge for covered services. Cigna Dental will pay the non-network dentist the difference, if any, between his or her usual fee and the applicable patient charge. For non-covered services or services not approved for payment, including adverse determinations, you must pay the dentist's usual fee.

B. Orthodontics. (This section is applicable only when orthodontics is listed on your *Patient Charge Schedule*.)

1. Definitions. If your *Patient Charge Schedule* indicates coverage for orthodontic treatment, the following definitions apply:
   - **a.** Orthodontic treatment plan and records – the preparation of orthodontic records and a treatment plan by the orthodontist.
   - **b.** Interceptive orthodontic treatment – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
   - **c.** Comprehensive orthodontic treatment – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.

d. Retention (post treatment stabilization) – the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

2. Patient charges. The patient charge for your entire orthodontic case, including retention, will be based upon the *Patient Charge Schedule* in effect on the date of your visit for treatment plan and records. However, if a). banding/appliance insertion does not occur within 90 days of such visit, b). your treatment plan changes, or c). there is an interruption in your coverage or treatment a later change in the *Patient Charge Schedule* may apply.

The patient charge for orthodontic treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the orthodontist's contract fee. If you require less than 24 months of treatment, your patient charge will be reduced on a pro-rated basis.

3. Additional charges. You will be responsible for the orthodontist's usual fees for the following non-covered services:

a. Incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances.

b. Orthognathic surgery and associated incremental costs.

c. Appliances to guide minor tooth movement.

d. Appliances to correct harmful habits.

e. Services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

4. Orthodontics in progress. If orthodontic treatment is in progress for you or your dependent at the time you enroll, the fee listed on the *Patient Charge Schedule* is not applicable. Please call Customer Service at 1-800-Cigna24 to find out if you are entitled to any benefit under the dental Plan.

Complex rehabilitation/multiple crown units

Complex rehabilitation is extensive dental restoration involving six or more "units" of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your network general dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your network general dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your *Patient Charge Schedule*. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your *Patient Charge Schedule* are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) plus an additional charge for each unit when six or more units are prescribed in your network general dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your *Patient Charge Schedule*.

What to do if there is a problem

For the purposes of this section, any reference to "you" or "your" also refers to a representative or dentist designated by you to act on your behalf.

Most problems can be resolved between you and your dentist. However, we want you to be completely satisfied with the dental Plan. That is why we have established a process for addressing your concerns and complaints. The complaint procedure is voluntary and will be used only upon your request.

A. Start with customer service

We are here to listen and to help. If you have a question about your dental office or the dental Plan, you can call the toll-free number to reach one of our Customer Service Representatives. We will do our best to respond upon

your initial contact or get back to you as soon as possible, usually by the end of the next business day. You can call Customer Service at 1-800-Cigna24 or you may write to us at P.O. Box 188047, Chattanooga, TN 37422-8047.

If you are unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the dentist providing you dental care, please contact Cigna at 1-800-Cigna24 and we will assist you in getting the care you need.

B. Appeals procedure

1. Problems concerning plan benefits, quality of care, or plan administration. The dental Plan has a two-step procedure for complaints and appeals.

a. Level one review ("complaint"). For the purposes of this section, a complaint means a written or oral expression of dissatisfaction with any aspect of the dental Plan's operation. A complaint is not (1) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to your satisfaction; nor (2) you or your dentist's dissatisfaction or disagreement with an adverse determination.

To initiate a complaint, submit a request in writing to the dental Plan stating the reason why you feel your request should be approved and include any information supporting your request. If you are unable or choose not to write, you may ask Customer Service to register your request by calling the toll-free number.

Within 5 business days of receiving your complaint, we will send you a letter acknowledging the date the complaint was received, a description of the complaint procedure and timeframes for resolving your complaint. For oral complaints, you will be asked to complete a one-page complaint form to confirm the nature of your problem or to provide additional information.

Upon receipt of your written complaint or one- page complaint form, Customer Service will review and/or investigate your problem. Your complaint will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving clinical appropriateness will be considered by a dental professional. A written resolution will be provided to you within 30 calendar days. If applicable, the written resolution will include a statement of the specific dental or contractual reasons for the resolution, the specialization of any dentist consulted, and a description of the appeals process, including the time frames for the appeals process and final decision of the appeal. If you are not satisfied with our decision, you may request an appeal.

b. Level two review ("appeal"). Cigna Dental will acknowledge your appeal in writing within 5 business days. The acknowledgment will include the name, address, and telephone number of the appeals coordinator. The review will be held at Cigna Dental Health's administrative offices or at another location within the service area, including the location where you normally receive services, unless you agree to another site.

Additional information may be requested at that time. Second level reviews will be conducted by an appeals committee, which will include:

1) An employee of Cigna Dental Health;
2) A dentist who will preside over the appeals panel; and
3) An enrollee who is not an employee of Cigna Dental Health.

Anyone involved in the prior decision may not vote on the appeals committee. If specialty care is in dispute, the committee will include a dentist in the same or similar specialty as the care under consideration, as determined by Cigna Dental. The review will be held and you will be notified in writing of the committee's decision within 30 calendar days.

Cigna Dental will identify the committee members to you and provide copies of any documentation to be used during the review no later than 5 business days before the review, unless you agree otherwise. You, or your designated representative if you are a minor or disabled, may appear in person or by conference call before the appeals committee; present expert testimony; and, request the presence of and question any person responsible for making the prior determination that resulted in your appeal.

Please advise Cigna Dental 5 days in advance if you or your representative plans to be present. Cigna Dental will pay the expenses of the appeals committee; however, you must pay your own expenses, if any, relating to the appeals process including any expenses of your designated representative.

The appeal will be heard and you will be notified in writing of the committee's decision within 30 calendar days from the date of your request. Notice of the appeals committee's decision will include a statement of the specific clinical determination, the clinical basis and contractual criteria used, and the toll-free telephone number and address of the Texas Department of Insurance.

2. Problems concerning adverse determinations

a. Appeals. For the purpose of this section, a complaint concerning an adverse determination constitutes an appeal of that determination. You, your designated representative, or your dentist may appeal an adverse determination orally or in writing. We will acknowledge the appeal in writing within 5 working days of receipt, confirming the date we received the appeal, outlining the appeals procedure, and requesting any documents you should send us. For oral appeals, we will include a one-page appeal form.

Appeal decisions will be made by a licensed dentist; provided that, if the appeal is denied and your dentist sends us a letter showing good cause, the denial will be reviewed by a specialty dentist in the same or similar specialty as the care under review. The specialty review will be completed within 15 working days of receipt.

We will send you and your dentist a letter explaining the resolution of your appeal as soon as practical but in no case later than 30 calendar days after we receive the request. If the appeal is denied, the letter will include:

1) The clinical basis and principal reasons for the denial.

2) The specialty of the dentist making the denial.

3) A description of the source of the screening criteria used as guidelines in making the adverse determination.

4) Notice of the rights to seek review of the denial by an independent review organization and the procedure for obtaining that review.

b. Independent review organization. If the appeal of an adverse determination is denied, you, your representative, or your dentist have the right to request a review of that decision by an independent review organization ("IRO".) The written denial outlined above will include information on how to appeal the denial to an IRO, and the forms that must be completed and returned to us to begin the independent review process.

In life-threatening situations, you are entitled to an immediate review by an IRO without having to comply with our procedures for internal appeals of adverse determinations. Call Customer Service to request the review by the IRO if you have a life-threatening condition and we will provide the required information.

In order to request a referral to an IRO, the reason for the denial must be based on a medical necessity determination by Cigna Dental. Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

c. Expedited appeals. You may request that the above complaint and appeal process be expedited if the timeframes under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary.

Investigation and resolution of expedited complaints and appeals will be concluded in accordance with the clinical immediacy of the case but will not exceed 1 business day from receipt of the complaint. If an expedited appeal involves an ongoing emergency, you may request that the appeal be reviewed by a dental professional in the same or similar specialty as the care under consideration.

d. Filing complaints with the Texas Department of Insurance. Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may file a complaint in writing with the Texas Department of Insurance at P.O. Box 149091, Austin, Texas 78714-9091, or toll-free at 1-800-252-3439.

The Department will investigate a complaint against Cigna Dental to determine compliance with insurance laws within 30 days after the Department receives your complaint and all information necessary for the Department to determine compliance. The Department may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1) Additional information is needed;
2) An on-site review is necessary;
3) We, the physician or dentist, or you do not provide all documentation necessary to complete the investigation; or
4) Other circumstances occur that are beyond the control of the department.

Cigna Dental cannot retaliate against a network general dentist or network specialty dentist for filing a complaint or appealing a decision on your behalf. Cigna Dental will not cancel or refuse to renew coverage because you or your dependent has filed a complaint or appealed a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

Treatment in progress

A. Treatment in progress for procedures other than orthodontics. If your dental treatment is in progress when you enroll in the Cigna Dental Plan, you should check to make sure your dentist is in the Cigna Dental Plan network by contacting Customer Service at 1-800-Cigna24 as treatment in progress will only be covered on an in-network basis. You can elect a new dentist at this time. If you do not, your treatment expenses will not be covered by the Cigna Dental Plan.

B. Treatment in progress for orthodontics. If orthodontic treatment is in progress for you or your dependent at the time you enroll in this dental Plan, the copays listed on your *Patient Charge Schedule* do not apply to treatment that is already in progress. This is because your enrollment in this dental Plan does not override any obligation you or your dependent may have under any agreement with an orthodontist prior to your enrollment. Cigna may make a quarterly contribution toward the completion of your treatment, even if your orthodontist does not participate in the Cigna Dental Health network. Cigna's contribution is based on the *Patient Charge Schedule* selected by your Employer and the number of months remaining to complete your interceptive or comprehensive treatment,

excluding retention. Please call Customer Service at 1-800-Cigna24 to obtain an *Orthodontics in progress* information form. You and your orthodontist should complete this form and return it to Cigna to receive confirmation of Cigna's contribution.

Disenrollment from the dental Plan termination of benefits

Except as otherwise provided in the sections titled *Extension/continuation of benefits* or in your group contract, disenrollment from the dental Plan/termination of benefits and coverages will be as follows:

A. Termination of your group
  1. Due to nonpayment of premiums, coverage shall remain in effect for 30 days after the due date of the premium. If the late payment is received within the 30-day grace period, a 20% penalty will be added to the premium. If payment is not received within the 30 days, coverage will be canceled on the 31st day and the terminated customers will be liable for the cost of services received during the grace period.
  2. Either the group or Cigna Dental Health may terminate the group contract, effective as of any renewal date of the group contract, by providing at least 60 days prior written notice to the other party.

B. Termination of benefits for you and/or your dependents
  1. The last day of the month in which premiums are not paid to Cigna Dental.
  2. The last day of the month in which eligibility requirements are no longer met.
  3. The last day of the month in which your group notifies Cigna Dental of your termination from the dental Plan.
  4. The last day of the month after voluntary disenrollment.
  5. Upon 15 days written notice from Cigna Dental due to fraud or intentional material misrepresentation or fraud in the use of services or dental offices.
  6. Immediately for misconduct detrimental to safe Plan operations and delivery of services.
  7. For failure to establish a satisfactory patient-dentist relationship, Cigna Dental will give 30 days written notification that it considers the relationship unsatisfactory and will specify necessary changes. If you fail to make such changes, coverage may be cancelled at the end of the 30-day period.

8. Upon 30 days' notice, due to neither residing, living nor working in the service area. Coverage for a dependent child who is the subject of a medical or dental support order cannot be cancelled solely because the child does not reside, live or work in the service area.

When coverage for one of your dependents ends, you and your other dependents may continue to be enrolled. When your coverage ends, your dependents coverage will also end.

Extension of benefits

Coverage for completion of a dental procedure (other than orthodontics) which was started before your disenrollment from the dental Plan will be extended for 90 days after disenrollment unless disenrollment was due to nonpayment of premiums.

Coverage for orthodontic treatment which was started before disenrollment from the dental Plan will be extended to the end of the quarter or for 60 days after disenrollment, whichever is later, unless disenrollment was due to nonpayment of premiums.

Continuation of benefits (COBRA)

For groups with 20 or more employees, federal law requires the employer to offer continuation of benefits coverage for a specified period of time after termination of employment or reduction of work hours, for any reason other than gross misconduct. You will be responsible for sending payment of the required premiums to the group. Additional information is available through your Benefits Representative.

Under Texas law you may also choose continuation coverage for you and your dependents if coverage is terminated for any reason except your involuntary termination for cause and if you or your dependent has been continuously covered for 3 consecutive months prior to the termination. You must request continuation coverage from your group in writing and pay the monthly premiums, in advance, within 60 days of the date your termination ends or the date your group notifies you of your rights to continuation. If you elect continuation coverage, it will not end until the earliest of:

1. 9 months after the date you choose continuation coverage if you or your dependents are not eligible for COBRA.
2. 6 months after the date you choose continuation coverage if you or your dependents are eligible for COBRA.
3. The date you and/or your dependent becomes covered under another dental plan.
4. The last day of the month in which you fail to pay premiums.
5. The date the group contract ends.

You must pay your group the amount of premiums plus 2% in advance on a monthly basis. You must make the first premium payment no later than the 45th day following your election for continued coverage. Subsequent premium payments will be considered timely if you make such payments by the 30th day after the date that payment is due.

Conversion coverage

If you are no longer eligible for coverage under your group's dental Plan, you and your enrolled dependents may continue your dental coverage by enrolling in the Cigna Dental conversion Plan. You must enroll within three months after becoming ineligible for your group's dental Plan. Premium payments and coverage will be retroactive to the date your group coverage ended. You and your enrolled dependents are eligible for conversion coverage unless benefits were discontinued due to:

A. Permanent breakdown of the dentist-patient relationship.
B. Fraud or misuse of dental services and/or dental offices
C. Nonpayment of premiums by the subscriber.
D. Selection of alternate dental coverage by your group.

Benefits for conversion coverage will be based on the then-current standard conversion Plan and may not be the same as those for your group's dental Plan. Premiums will be the Cigna Dental conversion premiums in effect at the time of conversion. Conversion premiums may not exceed 200% of Cigna Dental's premiums charged to groups with similar coverage. Please call the Cigna Dental Conversion Department at 1-800-Cigna24 to obtain rates and make arrangements for continuing coverage.

Confidentiality/privacy

Cigna Dental is committed to maintaining the confidentiality of your personal and sensitive information. Information about Cigna Dental's confidentiality policies and procedures is made available to you during the enrollment process

and/or as part of your customer Plan materials. You may obtain additional information about Cigna Dental's confidentiality policies and procedures by calling Customer Service at 1-800-Cigna24 or by visiting myCigna.com.

Miscellaneous

A. As a Cigna Dental Plan customer, you may also be eligible for additional dental benefits during certain health conditions. For example, certain frequency limitations for dental services may be relaxed for pregnant women and customers participating in certain disease management programs. Please review your Plan enrollment materials for details.

B. Notice: Any notice required by the group contract shall be in writing and mailed with postage fully prepaid and addressed to the entities named in the group contract.

C. Incontestability: All statements made by a subscriber on the enrollment application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, or non-renew an enrollee's coverage or reduce benefits unless it is in a written enrollment application signed by you, and a signed copy of the enrollment application is or has been furnished to you or your personal representative.

This Certificate of Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.

D. Entire agreement: The contract, pre-contract application, amendments and attachments thereto represent the entire agreement between Cigna Dental Health and your group. Any change in the group contract must be approved by an officer of Cigna Dental Health and attached thereto; no agent has the authority to change the group contract or waive any of its provisions. In the event this certificate contains any provision not in conformity with the Texas Health Maintenance Organization Act (the Act) or other applicable laws, this certificate shall not be rendered invalid but shall be construed and implied as if it were in full compliance with the Act or other applicable laws.

E. Conformity with state law: If this certificate of coverage contains any provision not in conformity with the Texas Insurance Code Chapter 1271 or other applicable laws, it shall not be rendered invalid but shall be considered and applied as if it were in full compliance with the Texas Insurance Code Chapter 1271 and other applicable laws.

BEK Vision Plan

Eligibility

Participation in the Ben E. Keith Vision Plan is open to eligible employees and their dependents. The eligibility rules for Plan participation can be found in the **Eligibility and enrollment** chapter, which also describes:

- When Plan participation begins.
- Cost of coverage.
- How to enroll.
- Changing your coverage during the year.
- When Plan participation ends.

Enrollment

Individuals who enroll themselves and their eligible dependents after their initial enrollment period are considered *late entrants*. You may not enroll until the next Annual Enrollment period unless you have a qualified life event as described in the **Eligibility and enrollment** chapter.

Description of coverage

The BEK Vision Plan benefits are provided through Superior Vision. This Plan provides you and your covered family members with diagnostic and corrective vision care benefits.

In-network benefits

When you enroll in coverage, an in-network provider directory will be made available to you with the names, phone numbers and addresses of in-network providers. A provider's status may occasionally change, so call Superior Vision at 1-800-507-3800 to verify the provider's network status. You may change providers at any time without notifying Superior Vision.

When benefits are payable for covered services or materials received from an in-network provider, we will pay the in-network provider directly based on the *Schedule of Benefits*, found on the last page of this chapter. You will be responsible for any required copays or any charges above the covered in-network benefits. Your provider is responsible for claims submission and other administrative services.

Note: If you use the services of an in-network provider but take advantage of a sale, coupon or other in-store special, the provider may require that you pay in full and submit your receipt for reimbursement as an out-of-network claim.

Limited in-network benefits may be payable for certain add-on materials. These items, if any, are shown in the supplement to the *Schedule of Benefits*.

Both the copay and the frequency for covered services or materials are shown in the *Schedule of Benefits*.

Out-of-network benefits

If you choose to use an out-of-network provider, you must pay the provider in full for the services and materials purchased. It is your responsibility to send us a claim by submitting an itemized invoice or receipt as described in the "Notice of Claim" provision. Any copay that applies should not be paid to the out-of-network providers, as it will be deducted from us at the time the claim is processed.

When benefits are payable for covered services or materials received from an out-of-network provider, we will reimburse you up to the amount of out-of-network benefits shown in the *Schedule of Benefits*, less any copay.

Covered services or materials

Covered services or materials are shown in the *Schedule of Benefits*. In order to be a covered service or materials, the services or materials must be furnished to an insured:

1. To check or improve their vision condition.
2. Within the allowable frequency shown in the *Schedule of Benefits*.
3. By an ophthalmologist, optometrist or optician, regardless of whether the provider is an in-network or out-of-network provider.

In no event will the coverage exceed the lesser of the actual cost of the covered services or materials or the limits of coverage shown in the *Schedule of Benefits*.

Limitations and exclusions

The contact lenses benefit is paid in lieu of eyeglass lenses and frames. You are eligible to receive benefits under the eyeglass lenses benefit or the frame benefit only after the contact lenses benefit frequency has ended.

The eyeglass lenses benefit and the eyeglass frame benefit is paid in lieu of the contact lenses benefit. You are eligible to receive benefits under the contact lenses benefit only after the eyeglass lenses benefit frequency has ended.

Coverage for a late entrant or re-enrollee is limited to the vision exam benefit during the first twenty-four (24) months after such person's effective date of coverage.

Exclusions

No benefits are payable for any of the following conditions, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the *Schedule of Benefits*:

- Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available.
- Plano or non-prescription lenses or sunglasses.
- Orthoptics, vision training and any associated supplemental testing.
- Frame cases.
- Low (subnormal) vision aids or aniseikonic lenses.
- Medical and surgical treatment of the eyes.
- Charges incurred after (a) the policy ends; or (b) the insured's coverage under the policy ends, except as stated in the policy.
- Experimental or non-conventional treatment or device.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.
- Services and materials provided by another vision plan except in the case of coordination of benefits.
- Services for which benefits are paid by Worker's Compensation.
- Benefits provided under the employee's medical insurance except in the case of coordination of benefits.
- Blended bifocal lenses.
- Groove, drill or notch, and roll and polish.
- Two (2) pairs of glasses, in lieu of bifocals, trifocals or progressives.
- Coating on lenses (factory scratch coat, anti-reflective, sunglass colors, etc.).
- Cosmetic items.
- Faceted lenses.
- High-Index Lenses.
- Laminated Lenses.
- Oversize Lenses – any lens with an eye size of 61mm or greater.
- Photochromic (Transition) lenses.
- Polaroid lenses.
- Polished bevel lenses.
- Polycarbonate lenses.
- Prism lenses.
- Slab-off lenses.
- Tints (except pink tint #1 and #2).
- Ultra-violet tint or coating.
- Additional cost for contact lenses over the allowance.
- Additional cost for a frame over the allowance.
- Progressive power lenses.

*Progressive Power Lens Benefit. If this type of lens is not a covered benefit, the provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens you have selected. You pay the provider the difference, if any, between the two (2).

Claim provisions

In-network claims
When you receive services from an in-network provider, the provider will handle all claims and administrative services for you. In-network providers submit charges directly to the administrator. (Note the exception under the *In-network benefits* section on the first page of this chapter.)

Out-of-network claims
In order to pay benefits for covered services or materials provided by an out-of-network provider, you must furnish written proof of loss. Your claim must be sufficient to identify the insured, the name of the policyholder and your group policy number. Contact Superior Vision for a claim form or submit itemized receipts for the services you received.

Notice of claim
Written notice of claim must be given within twenty (20) days after the loss starts or as soon as reasonably possible. Notice should be sent to:

National Guardian Life Insurance Company
c/o Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Claim forms
When the administrator receives notice of claim that does not contain all necessary information, forms for filing proof of loss will be sent to you along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, you will meet the proof of loss requirements if the administrator is given written proof of the nature and extent of the loss within the time stated in the following *Proof of loss* section.

Proof of loss
Written proof of loss must be given to the administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the administrator within one (1) year after it is due, unless you are legally incapable of doing so.

Payment of claims
Benefits will be paid within thirty (30) days after our administrator receives written proof of loss. Benefits will be paid to you unless an Assignment of Benefits has been requested by the insured. Benefits due and unpaid at your death will be paid to your estate. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

Time of payment of claims
Benefits payable under this policy will be paid immediately upon our receipt of written proof of loss.

Overpayments
If we pay a benefit and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess. This applies to payments made to you, to a covered dependent, or to the provider of the covered services or materials.

Coordination of Benefits (COB)
This provision applies when an insured has vision coverage under more than one plan, as defined below. The benefits payable between the plans will be coordinated.

Benefit coordination
Benefits will be adjusted so that the total payment under all plans is no more than 100 percent of the insured’s allowable expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an insured’s benefits paid under this plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

The order of benefit determination

1. When this is the primary plan, we will pay benefits as if there were no other plans.
2. When a person is covered by a plan without a COB provision, the plan without the provision will be the primary plan.
3. When a person is covered by more than one plan with a COB provision, the order of benefit payment is as follows:
   a) **Non-dependent/dependent.** A plan that covers a person other than as a dependent will pay before a plan that covers that person as a dependent.
   b) **Dependent child/parents not separated or divorced**. For a dependent child, the plan of the parent whose birthday occurs first in the calendar year will pay benefits first. If both parents have the same birthday, the plan that has covered the dependent child for the longer period will pay first. If the other plan uses gender to determine which plan pays first, we will also use that basis.
   c) **Dependent child/separated or divorce parents**. If two or more plans cover a person as a dependent of separated or divorced parents, benefits for the child are determined in the following order:
      i. The plan of the parent who has responsibility for providing insurance as determined by a court order.
      ii. The plan of the parent with custody of the child.
      iii. The plan of the spouse of the parent with custody.
      iv. The plan of the parent without custody of the child.
   d) **Dependent child/joint custody**: If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for *Dependent child/parents not separated or divorced* in section b) above, shall apply.
   e) **Active/inactive employee.** The plan which covers the person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary over the plan which covers that person as a laid off or retired employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
   f) **Longer/shorter length of coverage**. When an order of payment is not established by the above, the plan that has covered the person for the longer period of time will pay first.

Right to receive and release needed information

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to you or any claimant. You are required to give us information necessary for COB.

Right to make payments to another plan

COB may result in payments made by another plan that should have been made by us. We have the right to pay such other plan all amounts it paid which would otherwise have been paid by us. Amounts so paid will be treated as benefits paid under this plan. We will be discharged from liability to the extent of such payments.

Right to Recovery

COB may result in overpayments by us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

Grievance procedure

If a claim for benefits is wholly or partially denied, the insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an insured may file a grievance and make a written request for review to:

National Guardian Life Insurance Company
c/o Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

We will resolve the grievance within thirty (30) calendar days of receiving it. If we are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if we notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The insured or someone on his/her behalf also has the right to appear in person before our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this grievance procedure, a grievance is a written complaint submitted in accordance with the previously described grievance procedure by or on behalf of an insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the insured. In situations requiring urgent care, grievances will be resolved within seventy-two (72) hours of receiving the grievance.

General provisions

Cancellation
We may cancel the policy at any time by providing at least sixty (60) days advance written notice to the policyholder. The policyholder may cancel the policy at any time by providing written notice to us, effective upon our receipt of the notice or the date specified in the notice, if later. In the event of such cancellation by either us or the policyholder, we shall promptly return on a pro rata basis any unearned premium paid as required by the law of the state in which the policy is issued. The policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal actions
No legal action may be brought to recover on the policy before sixty (60) days after written proof of loss has been furnished as required by the policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

Schedule of Benefits

Plan benefits	In-network provider benefit	Out-of-network provider benefit
Vision exam (once every 12 months)		
Ophthalmologist (M.D.)	Covered in full with a $10 copay	Plan pays up to $42 with a $10 copay
Optometrist (O.D.)		Plan pays up to $37 with a $10 copay
Materials – eyeglass lenses (once every 12 months)		
Lens options (once every 12 months)		
Single vision	Covered in full with a $20 copay	Plan pays up to $26 with a $20 copay
Bifocal		Plan pays up to $34 with a $20 copay
Trifocal		Plan pays up to $50 with a $20 copay
Lenticular		Plan pays up to $80 with a $20 copay
Progressive	Covered up to the provider's retail trifocal amount with a $20 copay	Plan pays up to $50 with a $20 copay
Frames (once every 12 months)	Plan pays up to $130 with a $20 copay	Plan pays up to $52 with a $20 copay
Contact lenses (once every 12 months)		
Non-elective (once every 12 months – instead of eye glass lenses and frames)	Covered in full	Plan pays up to $210
Elective (once every 12 months – instead of eye glass lenses and frames)	Plan pays up to $150	Plan pays up to $100
Contact lens fit (once every 12 months)		
Standard	Covered in full with a $20 copay	Not covered
Specialty	Plan pays up to $50 with a $20 copay	Not covered

BEK Life and Accidental Death & Dismemberment (Life/AD&D)

You protect your family every day – your paycheck keeps a roof over their heads and food on the table. What would happen to your family if you died? Would they be able to cope with the financial situation you leave behind? In addition to your Ben E. Keith Company-provided life and accidental death and dismemberment insurance, you can choose to enroll yourself and your eligible dependents in supplemental life/AD&D coverage.

What you need to know

- All full-time Ben E. Keith Company employees receive Company-paid BEK Basic Life/AD&D on the first day of the month following 60 days of full-time employment (or 30 days for Southeast Division and Kelley Manufacturing employees).
- You can choose to enroll in additional supplemental life/AD&D insurance for yourself, your spouse and/or children.

To find:	Go to or call:
An online version of this **Life/AD&D** chapter	bek.family under the **Resources** section, accessible through the menu
To enroll in life/AD&D or to complete a qualified life event declaration	dayforcehcm.com
File a claim or to learn more about your life/AD&D benefits	mylincolnportal.com using Company code **BEKCO** or call 1-888-408-7300

Eligibility – Schedule of Benefits

Active, full-time employees who work a minimum of 30 regularly scheduled hours per week are eligible to enroll in BEK Supplemental Employee Life/AD&D coverage. In addition, employees can enroll their eligible dependents in spouse and child life/AD&D coverage.

Temporary and seasonal employees, and employees who are not legal residents working in the United States are not eligible to receive BEK Basic Life/AD&D or enroll in supplemental life/AD&D insurance plans.

Eligibility waiting period

Applicable to Basic Insurance:

Active, full-time Ben E. Keith Company employees (non-Southeast Division or Kelley Manufacturing employees)

1. If the covered person is employed by the Sponsor on the policy effective date first of the month following 60 days of continuous, active employment.
2. If the covered person begins employment for the Sponsor after the policy effective date first of the month following 60 days of continuous, active employment.

Active, full-time Southeast Division or Kelley Manufacturing employees (non-Ben E. Keith Company employees)

1. If the covered person is employed by the Sponsor on the policy effective date first of the month following 30 days of continuous, active employment.
2. If the covered person begins employment for the Sponsor after the policy effective date first of the month following 30 days of continuous, active employment.

Applicable to Optional Insurance:

Active, full-time Ben E. Keith Company employees (non-Southeast Division or Kelley Manufacturing employees)

1. If the covered person is employed by the Sponsor on the policy effective date first of the month following 60 days of continuous, active employment.
2. If the covered person begins employment for the Sponsor after the policy effective date first of the month following 60 days of continuous, active employment.

Active, full-time Southeast Division or Kelley Manufacturing employees (non-Ben E. Keith Company employees)

1. If the covered person is employed by the Sponsor on the policy effective date first of the month following 30 days of continuous, active employment.
2. If the covered person begins employment for the Sponsor after the policy effective date first of the month following 30 days of continuous, active employment.

Plan	Benefit amount	Employee contributions required
Employee Basic Life Insurance (BEK Basic Life/AD&D)	$50,000	No
Employee Optional Life Insurance (BEK Employee Supplemental Life/AD&D)	An amount in increments of $50,000.00. This amount may not exceed $950,000.00. The minimum amount is $50,000.00.	Yes
Dependent Optional Life Insurance (BEK Spouse Life/AD&D)	An amount in increments of $50,000.00. This amount may not exceed $250,000.00. The minimum amount is $50,000.00. The amount may not exceed 100% of the amount of BEK Employee Supplemental Life/AD&D.	Yes
Dependent Optional Life Insurance (BEK Child Life/AD&D)	Children (age at death): Live birth, but under 26 years. $1,000 – live birth to 14 days $10,000 – 15 days to 26 years	Yes

Additional Accidental Death and Dismemberment Insurance

Benefit	Maximum benefit amount
Employee seatbelt benefit	10.00% of full amount up to $25,000
Employee air bag benefit	5.00% of full amount up to $5,000
Employee repatriation benefit	$5,000
Applicable to Basic Insurance	
Employee common carrier benefit	$50,000
Applicable to Optional Insurance	
Employee common carrier benefit	Full amount up to $950,000
Employee child education benefit: • Maximum annual benefit (per dependent child) • Maximum lifetime family benefit amount Dependent children maximum age	 • $6,000.00 • $24,000.00 26 years

Reduction formula

Applicable to Basic Insurance

The amount of Life and Accidental Death and Dismemberment Insurance applicable to the covered person's class of benefits will reduce at age 70 or older as follows:

Ages 70 & up: to 65%

Applicable to Optional Insurance:
The amount of Life and Accidental Death and Dismemberment Insurance applicable to the covered person's class of benefits will reduce at age 70 or older as follows:

Ages 70 – 74: to 65%
Ages 75 & up: to 50%

IMPORTANT NOTE: Reduced amounts shall take effect on the January 1st immediately following the date the covered employee reaches the applicable age.

Evidence of Insurability requirements non-medical maximum

Employee Optional Life Insurance benefits	$300,000
Dependent Spouse Optional Life Insurance benefits	$50,000

Any amounts of insurance in excess of the amount shown above that are due solely to salary increases are not subject to Evidence of Insurability.

Annual Enrollment

Employee Optional Life Insurance benefits	Any increases of more than one level above the current benefit level will be subject to Evidence of Insurability
Any increases elected during Annual Enrollment will be subject to evidence of insurability if an employee has previously been denied coverage. The non-medical maximum will apply to any changes made during the Annual Enrollment period.	
Dependent Spouse Optional Life Insurance benefits	Any increases of more than one level above the current benefit level will be subject to Evidence of Insurability

Qualified life event

Employee Optional Life Insurance benefits	Any increases of more than one level above the current benefit level will be subject to Evidence of Insurability
Any increases elected due to a qualified life event will be subject to Evidence of Insurability if an employee has previously been denied coverage. The non-medical maximum will apply to any changes made due to a qualified life event.	
Dependent Spouse Optional Life Insurance benefits	Any increases of more than one level above the current benefit level will be subject to Evidence of Insurability

Eligibility and effective dates

Eligibility requirements for Employee and Dependent Insurance benefits
The eligibility requirements for insurance benefits are shown in the *Schedule of Benefits* earlier in this chapter.

Eligibility date for insurance benefits
Employee coverage
If the employee is in an eligible class he or she will qualify for insurance on the later of:
1. This policy's effective date; or
2. The day after he or she completes the eligibility waiting period shown in the *Schedule of Benefits*.

Dependent coverage:
If the employee is eligible for employee coverage, he or she will be eligible for dependent coverage on the later of:
1. The date he or she is eligible for employee coverage if on that date he or she has a dependent; or
2. The date he or she acquires a dependent if on that date he or she is eligible for employee coverage.

If both parents are employees, only one will be eligible for dependent coverage with respect to their dependent children.

Annual Enrollment period

During each Annual Enrollment period, an employee may keep his or her coverage at the same level or make any one of the following changes in coverage for the next policy year, subject to any evidence of insurability requirements as shown in the *Schedule of Benefits*:

1. Decrease his or her coverage; or
2. Increase his or her coverage including enrolling for the first time.

If an employee fails to enroll for a change in his or her coverage option during any Annual Enrollment period, he or she will continue to be insured for the same coverage option during the next policy year, unless the covered employee experiences a qualified life event.

Qualified life event

When a covered employee experiences a qualified life event, a covered employee may keep his coverage at the same level or make any one of the following changes in coverage, subject to any evidence of insurability requirements as shown in the *Schedule of Benefits*:

1. Decrease his or her coverage; or
2. Increase his or her coverage including enrolling for the first time.

The covered employee must apply for the change in coverage within 31 days of the date of the qualified life event. Such changes in coverage must be due to or consistent with the reason that the change in coverage was permitted. A change in coverage is consistent with a qualified life event only if it is necessary or appropriate as the result of the qualified life event.

Effective date for insurance benefits

Insurance will be effective at 12:01 a.m. Standard Time in the governing jurisdiction on the day determined as follows, but only if the employee's application or enrollment for insurance is made with Lincoln through the Sponsor in a form or format satisfactory to Lincoln.

Employee coverage:

1. For non-contributory coverage not subject to evidence of insurability, the covered employee will be insured on his or her eligibility date.
2. For non-contributory coverage subject to evidence of insurability, the covered employee will be insured on the later of the date Lincoln gives approval or his or her eligibility date.
3. For contributory coverage not subject to evidence of insurability, the covered employee will be insured on the later of the date he or she makes application or his or her eligibility date, provided he or she makes application no later than 31 days after his or her eligibility date.
4. For contributory coverage subject to evidence of insurability, the covered employee will be insured on the later of the date Lincoln gives approval or his or her eligibility date, provided he or she makes application no later than 31 days after his or her eligibility date.

Evidence of insurability will be at the covered employee's expense.

Increases or decreases:

Any increase in or addition to coverage will take effect on the date of the change.

Any decrease in or deletion of coverage will take effect on the date of the change.

Any such change applies to loss of life or accidental Injury that occurs on or after the effective date of the change.

Delayed effective date for employee insurance

The effective date of any initial, increased or additional insurance will be delayed for an individual if he or she is not in active employment because of injury or sickness. The initial, increased or additional insurance will begin on the date the individual returns to active employment.

Delayed effective date for dependent insurance

If a covered dependent is confined on the date the increase or addition is to take effect, it will take effect when the confinement ends. This delayed effective date will not apply to newborn children.

Family and Medical Leave
A covered employee's coverage may be continued under this policy for an approved family or medical leave of absence for up to 12 weeks following the date coverage would have terminated, subject to the following:

1. The authorized leave is in writing;
2. The required premium is paid;
3. The covered employee's benefit level, or the amount of earnings upon which the covered employee's benefit may be based, will be that in effect on the date before said leave begins; and
4. Continuation of coverage will cease immediately if any one of the following events should occur:
   a. The covered employee returns to work;
   b. This policy terminates;
   c. The covered employee is no longer in an eligible class;
   d. Nonpayment of premium when due by the Sponsor or the covered employee; and
   e. The covered employee's employment terminates.

Lay-off
The Sponsor may continue the covered employee's coverage(s) by paying the required premiums, if the covered employee is temporarily laid off.

The covered employee's coverage(s) will not continue beyond the end of the policy month following the policy month in which the lay-off begins. In continuing such coverage(s) under this provision, the Sponsor agrees to treat all covered employees equally.

Leave of absence
The Sponsor may continue the covered employee's coverage(s) by paying the required premiums, if the covered person is granted an approved leave of absence.

The covered employee's coverage(s) will not continue beyond the end of the policy month following the policy month in which the leave of absence begins. in continuing such coverage(s) under this provision, the sponsor agrees to treat all covered employees equally.

Leave of absence due to disability
The Sponsor may continue the covered employee's coverage(s) by paying the required premiums, if the covered employee is granted an approved leave of absence due to a disability.

The covered employee's coverage(s) will not continue beyond a period of 12 months. In continuing such coverage(s) under this provision, the Sponsor agrees to treat all covered employees equally.

Rehire terms
If a former employee is re-hired by the Sponsor within 30 days of his termination date, all past periods of active employment with the Sponsor will be used in determining the re-hired employee's eligibility date. If a former employee is re-hired by the Sponsor more than 30 days after his or her termination date, he or she is considered to be a new employee when determining his or her eligibility date.

Continuation during a labor dispute
A covered employee whose coverage under this policy ends because he or she stops active work as a result of a labor dispute may have the right to have continued coverage. To continue coverage, the required premium must be paid to the Sponsor when due.

To qualify for continued coverage, a covered employee must have been covered by this policy on the date of cessation of work.

If any premium was due prior to the date of cessation of work and is unpaid at the date of cessation of work, continuation may be contingent upon payment of such premium.

Payment for continued coverage
The covered employee must pay his or her individual contribution of premium and any contribution due from the employer for the period of cessation of work. The premium will be 100% of the total employer and employee cost of providing the same benefits if the cessation of work had not occurred. The individual premium rate may be increased up to an additional 20%, or a higher percent if approved by the Commissioner of Insurance of Texas.

Benefits under continued coverage
This continued coverage will at all times provide the same benefits as would have been afforded to the covered employee had the work cessation not occurred. This includes any changes in the coverage under this policy as may become effective while continued coverage is in effect.

Termination of continued coverage
A covered employee's continued coverage under this provision will end at the earliest of these dates:

- The date which ends the "maximum period" as defined below;
- The date ending the last period for which the covered person has made any required payment for continued coverage on a timely basis;
- The date work cessation ends;
- The date on which the number of persons for which premium is paid is less than 75% of those eligible to continue coverage; or
- The date a covered employee takes full-time employment with another employer.

The "maximum period" referred to previously will start with the first day of the period of work cessation and will end with the date six (6) months after the work cessation began.

Employee life insurance (BEK Employee Supplemental Life/AD&D)

Benefits
When Lincoln receives satisfactory proof of the covered employee's death, Lincoln will pay the proceeds of the life insurance in force on the covered employee's life under this policy. The benefit payable is shown in the *Schedule of Benefits*.

Conversion privilege at individual termination or reduction of benefits:
If all or part of a covered employee's coverage ends, the covered employee may convert the amount that ends to an individual life insurance policy. Conversion is subject to the following conditions:

1. Within 31 days after coverage ends or is reduced, the covered employee must make written application to Lincoln and pay the first premium payment.
2. The individual policy will be issued without evidence of insurability. It will contain life insurance benefits only. The policy will be one then being offered by Lincoln. The premium due will be based on the premium schedule of Lincoln's conversion policy that applies to the covered employee's class of risk and age at the birthday nearest to the effective date of the individual policy.

The individual policy will be effective 31 days after the covered employee's group coverage ends.

Conversion privilege at class or policy termination:
If coverage ends for all employees or for a covered employee's class, the covered employee is entitled to a limited conversion privilege. The covered employee must have been covered for at least 5 years. The covered employee must apply for the individual policy in the same manner as described previously. The amount the covered employee may convert is limited to the lesser of:

1. The amount the covered employee was covered for on the date the group coverage terminated less any group insurance he or she becomes eligible for within 31 days; or
2. $2,000.

The individual policy will be effective 31 days after the covered employee's group coverage ends.

Death within the 31 days allowed for conversion:
If a covered employee dies within the 31 days allowed for conversion, Lincoln will pay to his beneficiary the amount he or she was eligible to convert. Such insurance will be paid as a claim under this policy. Any premiums paid for a converted policy will be refunded.

Accelerated death benefit
If, while insured under this policy, a covered employee or covered dependent spouse gives Lincoln satisfactory proof of having a terminal condition, the covered employee or covered dependent spouse may receive a portion of his life insurance as an accelerated death benefit. Such insurance will be paid one time to the covered employee or covered dependent spouse in one lump sum.

Applicable to Basic Life Insurance
The amount of accelerated death benefit payable under this policy is limited to the lesser of the following:
1. The accelerated death benefit amount requested by the covered employee;
2. 50.00% of the covered employee's life insurance that is in force on the date the covered employee applies for an accelerated death benefit; or
3. $25,000.00.

Applicable to Optional Life Insurance
The amount of accelerated death benefit payable under this policy is limited to the lesser of the following:
1. The accelerated death benefit amount requested by the covered employee;
2. 75.00% of the covered employee's life insurance that is in force on the date the covered employee applies for an accelerated death benefit; or
3. $150,000.00.

The amount of accelerated death benefit payable to the covered dependent spouse under this policy is limited to the lesser of the following:
1. The accelerated death benefit amount requested by the covered dependent spouse;
2. 75.00% of the covered dependent spouse's life insurance that is in force on the date the covered dependent spouse applies for an accelerated death benefit; or
3. $187,500.00.

If the amount of a covered employee's or covered dependent spouse's life insurance under this policy is scheduled to reduce within 24 months following the date the covered employee or covered dependent spouse applies for the accelerated death benefit, the benefit payable under this policy will be based on the reduced amount.

A covered employee or covered dependent spouse must apply for an accelerated death benefit. to apply, the covered employee or covered dependent spouse must give Lincoln:
1. Certification, from a physician, that he or she has a terminal condition, as defined by this policy;
2. Supporting evidence satisfactory to Lincoln, documenting the terminal condition;
3. A completed claims form;
4. A claim disclosure form for accelerated death benefit agreement.

During the pendency of a claim, Lincoln may, at its own expense, have a physician examine the covered employee or covered dependent spouse. If there are conflicting opinions between the covered employee's or covered dependent spouse's physician and Lincoln’s physician, the medical opinion issued by the covered employee's or covered dependent spouse's physician will rule. If the covered employee or covered dependent spouse has assigned all or a portion of the life insurance under this policy or named an irrevocable beneficiary, the covered employee or covered dependent spouse must also give Lincoln a signed written consent form from the assignee or irrevocable beneficiary.

The accelerated death benefit will be payable upon receipt of satisfactory proof of a terminal condition; and signed written consent from an assignee or irrevocable beneficiary, if required.

With respect to this provision "terminal condition" means an illness or physical condition, including a physical injury:
1. Which is expected to result in the covered employee's or covered dependent spouse's death within 12 months; and
2. From which there is no reasonable prospect of recovery.

Effect on insurance
The amount of a covered employee's or covered dependent spouse's life insurance will be reduced by the amount paid as an accelerated death benefit. Premiums, if any, for the remaining portion of a covered employee's or covered dependent spouse's life insurance will be based on the amount of the remaining life insurance in effect after payment of the accelerated death benefit. All other terms and provisions of this policy will apply to the remaining portion. The acceleration-of-life-insurance benefits, related charges, interest, discounts or liens, if applicable, and the balance of the death benefit of the life insurance policy, which will be paid upon the covered employee's or covered dependent spouse's death, shall constitute full settlement on maturity of the face amount of the policy. Receipt of an accelerated death benefit does not affect any accidental death or dismemberment insurance benefit in force on a covered employee's or covered dependent spouse's life.

When an accelerated death benefit is paid, the covered employee or covered dependent spouse will receive a notice which specifies:

1. The amount of benefits paid;
2. The effect of the accelerated death benefit payment on the death benefit face amount, specified amount, future charges, and future premiums; and
3. The amount of remaining life insurance.

Exceptions

No accelerated death benefit will be paid if:

1. The covered employee or covered dependent spouse is required by a court of law to exercise this option to satisfy a claim of creditors, whether in bankruptcy or otherwise;
2. The covered employee or covered dependent spouse is required by a governmental agency to exercise this option in order to apply for, receive, or continue a government benefit or entitlement;
3. All or a part of a covered employee's insurance must be paid to the covered employee's children or spouse or former spouse as part of a divorce decree, separate maintenance agreement or property settlement agreement;
4. The covered employee is married and lives in a community property state, unless the covered employee's spouse has given Lincoln signed written consent; or
5. The covered employee or covered dependent spouse has previously received an accelerated death benefit under this policy.

Dependent life insurance

Benefits

When Lincoln receives satisfactory proof of the covered dependent's death, Lincoln will pay to the covered employee the amount in force on such covered dependent's life under this policy. The dependent life insurance benefit will be paid in one sum. It is shown in the *Schedule of Benefits* earlier in this chapter.

Conversion privilege at individual termination or reduction of benefits:

If a covered dependent's coverage ends because:

1. Of the covered employee's death; or
2. The covered employee's employment in an eligible class for dependent life insurance ends.

The covered employee's covered dependent spouse may convert dependent life insurance to an individual policy. Within 31 days after coverage ends, the covered dependent spouse must make written application to Lincoln and pay the first premium payment. The individual policy will contain life insurance benefits only. The policy will be one then being offered by Lincoln. Evidence of insurability will not be required.

Conversion privilege at class or policy termination:

If a covered dependent's coverage ends because:

1. Coverage ends for all employees; or
2. Coverage ends for all employees in the covered employee's eligible class,

The covered dependent spouse is entitled to a limited conversion privilege. The covered employee must be entitled to convert to an individual policy in order for his covered dependent spouse to have this limited privilege. Conversion must be applied for in the same way as stated above. The amount the covered dependent spouse may convert is limited to the lesser of:

1. The amount the covered dependent spouse was covered for on the date coverage ended less any group insurance he or she becomes eligible for within 31 days; or
2. $2,000.

The individual policy will become effective 31 days after the covered dependent spouse's coverage ends.

Death within the 31 days allowed for conversion:

Dependent life insurance is payable if a covered dependent spouse dies during this period. The amount payable is the amount the covered dependent spouse was entitled to convert. Such insurance will be paid under this policy. Any premium paid for an individual policy will be refunded.

Employee and dependent accidental death and dismemberment insurance benefits
Accidental death and dismemberment benefits are payable when a covered person suffers a loss solely as the result of accidental injury that occurs while covered. The loss must occur within 365 days after the date of the accident. The benefit payable is called the “full amount” and is shown in the *Schedule of Benefits.*

Loss schedule	Benefit payable
Life	Full amount
Both hands or both feet	Full amount
Sight of both eyes	Full amount
One hand and one foot	Full amount
One hand and sight of one eye	Full amount
One foot and sight of one eye	Full amount
Speech and hearing in both ears	Full amount
One hand or one foot	One-half full amount
Sight of one eye	One-half full amount
Speech or hearing in both ears	One-half full amount
Thumb and index finger of the same hand	One-quarter full amount
Quadriplegia	Full amount
Paraplegia	Three-quarters full amount
Hemiplegia	One-half full amount
Diplegia	One-half full amount
Monoplegia	One-quarter full amount

Payment is made for loss due to each accident without regard to loss resulting from any prior accident. In no event may the total amount payable for all losses due to any one accident exceed the full amount.

- Loss of hands or feet means complete severance through or above the wrist or ankle joint.
- Loss of sight, speech or hearing must be total and irrecoverable.
- Loss of thumb and index finger means that all of the thumb and index finger are cut off at or above the joint closest to the wrist. This benefit is not payable if a benefit is payable for the loss of the same entire hand.
- Quadriplegia means the total and permanent paralysis of both upper and lower limbs.
- Paraplegia means the total and permanent paralysis of both lower limbs.
- Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.
- Diplegia means the total and permanent paralysis of both arms.
- Monoplegia means the total and permanent paralysis of one arm or one leg.

Seat belt benefit
Lincoln will pay an additional benefit if accidental death was caused by an automobile accident while the covered person was driving or riding in an automobile and the covered person was covered by this policy. The benefit is payable if the covered person was wearing a seat belt at the time of the accident. The benefit payable is shown in the *Schedule of Benefits*.

Lincoln must be given satisfactory written proof that the covered person's death resulted from an automobile accident while wearing a seat belt. A copy of the police accident report should be submitted with the claim.

No benefit will be paid if the covered person was the driver of the automobile and did not hold a current valid driver's license.

Air bag benefit
Lincoln will pay an additional benefit if accidental death was caused by an automobile accident while the covered person was driving or riding in an automobile and the covered person was covered by this policy. The benefit is payable if the covered person was wearing a seat belt at the time of the accident and was seated behind a properly installed air bag. The benefit payable is shown in the *Schedule of Benefits*.

Lincoln must be given satisfactory written proof that the covered person's death resulted from an automobile accident while wearing a seat belt and the automobile was equipped with an air bag directly in front of the covered person. A copy of the police accident report should be submitted with the claim.

No benefit will be paid if the covered person was the driver of the automobile and did not hold a current valid driver's license.

With respect to this provision, "air bag" means the passive restraint device in an automobile which inflates automatically upon collision to provide protection in Automobile accidents. The air bag must meet the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration and be installed by the manufacturer.

With respect to this provision, "automobile" means a private passenger motor vehicle licensed for use on public highways.

With respect to this provision, **"**seat belt" means a combination lap and shoulder restraint system that must meet the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration and be installed by the manufacturer. A seat belt will include a lap belt alone, but only if the automobile did not have a combination lap and shoulder restraint system when manufactured. Seat belt does not include a shoulder restraint alone.

Repatriation benefit
Lincoln will pay an additional benefit for the transportation of the covered person's body to a mortuary chosen by the covered person or beneficiary. Payment will be made in the event the covered person suffers loss of life at least 200 miles from the covered person's principal place of residence. Written proof of the expenses must be submitted to Lincoln prior to payment. The benefit payable is shown in the *Schedule of Benefits*.

Exposure benefit
Lincoln will pay a benefit to the covered person or beneficiary in the event the covered person suffers a loss from exposure to the elements of nature by reason of a covered injury. The benefit payable is shown on the *Loss schedule* in the accidental death and dismemberment provision on the previous page.

Disappearance benefit
Lincoln will pay a benefit to the beneficiary in the event the body of the covered person is not found within 365 days after the disappearance, sinking or wrecking of a public conveyance in which the covered person was known to be a fare-paying passenger. The covered person will be presumed to have died resulting from injury caused by an accident. The benefit payable is equal to the full amount payable under accidental death and dismemberment shown in the *Schedule of Benefits*.

With respect to this provision, "passenger" is defined as an individual other than a pilot, operator or crew member who is riding in or on, boarding, or dismounting from a public conveyance.

Common carrier benefit
Lincoln will pay an additional benefit to the beneficiary if the covered person suffers loss of life as a result of an accident occurring while riding as a fare-paying passenger on a public conveyance. The benefit payable is equal to the full amount payable under accidental death and dismemberment up to the maximum benefit shown in the *Schedule of Benefits*.

With respect to this provision, "common carrier" means a public conveyance operated by a licensed common carrier for the transportation of the general public for a fare and operating on regular passenger routes, within the continental United States, Alaska and Hawaii, with a definite schedule of departures and arrivals.

With respect to this provision, "passenger" is defined as an individual other than a pilot, operator or crew member who is riding in or on, boarding, or dismounting from a public conveyance.

Child education benefit

Lincoln will pay a one-time benefit to the covered person or beneficiary on behalf of the covered person's dependent children if the covered employee suffers loss of life as a result of an accident provided:

1. The dependent child meets the definition of dependent under this policy; and
2. Satisfactory proof is furnished to Lincoln that the child is a dependent child; and
3. On the date of the accident the dependent child was at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning within 365 days of the covered person's death; or
4. The dependent child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning.

The one-time benefit payable is shown in the *Schedule of Benefits*. A benefit will not be payable beyond the earlier of:

a. 4 years;
b. The attainment of a bachelor's degree; or
c. The attainment of the dependent maximum age shown in the *Schedule of Benefits*.

The maximum benefit payable under this provision is shown in the *Schedule of Benefits*.

Waiver of premium for total disability

If a covered employee becomes totally disabled while insured under this policy, he or she may be eligible for continued life insurance coverage without premium payment, provided that:

1. He or she becomes totally disabled while insured under this policy and before age 60;
2. Within one year from the date he or she is no longer in active employment Lincoln receives initial proof that his or her total disability has continued for 9 months (initial proof); and
3. During the three months before each anniversary of receipt of initial proof, Lincoln receives proof of continuation of total disability. Lincoln will not request such proof more often than once every three months.

In addition, Lincoln, at its own expense, may request the covered employee to be examined by a physician chosen by Lincoln. After the benefit has been continued for two years under this provision, Lincoln will not require an examination more than once a year.

When proof of total disability has been approved, premiums will be waived beginning the later of:

1. The date Lincoln gives approval; or
2. 9 months from the date the covered employee is no longer in active employment due to total disability.

Accidental Death and Dismemberment and dependent coverage will not be continued during the covered employee's period of total disability.

The life insurance benefit continued under this provision will be the amount in force on the covered employee's life under this policy on the date the covered employee is no longer in active employment due to total disability, subject to any reductions provided by any part of this policy. The amount continued will not include any part of the covered employee's life insurance that he or she converted to an individual policy unless he or she was totally disabled when he or she applied to convert and he or she returns the converted policy to Lincoln without claim other than for a refund of the premiums.

If the waiver of premium provision has been denied, the covered employee may convert his life insurance benefit as provided in the conversion privilege.

A covered employee's continued life insurance coverage under this provision will end on the earliest of the date when:

1. He or she recovers and ceases to be totally disabled;
2. He or she returns to active employment;
3. He or she refuses to have an examination by a physician chosen by Lincoln or fails to give satisfactory proof of continuation of total disability;
4. 90 days after the date Lincoln mails the covered employee a request for additional proof of loss, Lincoln does not receive such proof;
5. He or she reaches age 65;
6. The date he or she begins receiving a benefit from a retirement or pension plan; or
7. The date the Sponsor classifies him or her as retired.

Waiver of premium for total disability
If continued life insurance coverage under this provision ends or reduces, the covered employee may convert his life insurance benefit as provided in the conversion privilege. Dependent coverage may be converted as allowed within this policy.

If the covered employee dies within one year from the date he or she is no longer in active employment due to total disability, Lincoln will pay the life insurance benefit provided satisfactory proof of continuous total disability until death is given to Lincoln within one year after death.

If this policy terminates before the covered employee has received approval of waiver of premium, he or she is eligible to convert to an individual policy until such approval has been received. If this policy terminates after approval for waiver of premium, coverage will continue as if this policy continued to be in force.

With respect to this provision, "total disability" or "totally disabled" means the complete inability, as a result of injury or sickness, to perform the material and substantial duties of any occupation.

With respect to this provision, "material and substantial duties" means responsibilities that are normally required to perform any occupation, and cannot be reasonably eliminated or modified.

With respect to this provision, "any occupation" means any occupation that the covered employee is or becomes reasonably fitted by training, education, experience, age, physical and mental capacity.

Portable group term life insurance
If any of a covered person’s coverage under this policy ends, he or she may be eligible to continue all or a part of the amount that ends, less any amount converted to an individual policy as provided in the conversion privilege, subject to any minimum and maximum amounts specified in this provision, as portable group term life insurance. The coverage must end because the covered employee is no longer in an eligible class or is no longer in active employment.

A covered employee whose group term life insurance terminates because he or she is no longer in active employment due to retirement as determined by the Sponsor’s records is eligible to continue all or a part of the amount that ends.

If a covered employee is eligible for portable group term life insurance, he or she may also elect portable group term life insurance on his covered dependent spouse or dependent child whose coverage under this policy ends. A covered dependent is eligible to directly apply for portable group term life insurance if they no longer satisfy the definition of dependent under the policy.

Portable group term life insurance is not available if coverage ends because this policy terminates, or if any life insurance under this policy will be continued on a waiver of premium basis.

A covered person is eligible to apply for portable group term life insurance if he or she has no injury or sickness that has a material effect on his life expectancy.

An injury or sickness that has a material effect on life expectancy means a condition that, according to generally accepted medical opinion, may contribute to or result in death within the next 5 years. Some examples include cancers and lung diseases.

Any covered person is eligible for portable group term life insurance if:
1. He or she is under age 65;
2. He or she is a citizen or legal resident of the United States or Canada; and
3. He or she is not a full-time member of the armed forces of any country.

To apply for portable group term life insurance, a covered person must, within 31 days of the date a covered person ceases to be eligible for coverage under this policy submit a completed portable group term life insurance application along with the first premium payment and any required application fee to Lincoln at the address shown on the application.

If a covered person is applying for coverage his portable group term life insurance will be effective at 12:01 a.m. Standard Time on the day after coverage under this policy ends as long as any required evidence of insurability is approved. A covered person is responsible for the expense of securing supporting information to satisfy Evidence of Insurability.

The policy available will be one then being offered by Lincoln as portable group term life insurance. The premium due will be based on Lincoln's then current rate for such policies that apply to the covered employee, covered dependent spouse and covered dependent child's class of risk and age at birthday nearest to the effective date of portable group term life insurance.

The amount of portable group term life insurance may be decreased at any time. Once elected, the amount of portable group term life insurance may be increased annually, subject to evidence of insurability and policy maximums.

Covered employee portable group term life insurance
The amount of portable group term life insurance a covered employee may apply for is subject to the following limits:

1. The maximum amount is equal to the lesser of:
   a. The amount of insurance that terminated under this policy; or
   b. $1,000,000.00.
2. The minimum amount is $10,000.00.

This amount is subject to any reductions due to age that may be contained in the portable group term life insurance policy.

Covered dependent spouse portable group term life insurance
The amount of portable group term life insurance a covered dependent spouse may apply for is subject to the following limits:

1. The maximum amount is equal to the lesser of:
   a. The amount of insurance that terminated under this policy; or
   b. $500,000.00.
2. The minimum amount is $5,000.00.

This amount is subject to any reductions due to age that may be contained in the portable group term life insurance policy.

Dependent child portable group term life insurance
An eligible person may apply for portable group term life insurance for their covered dependent child, subject to the following limits:

1. The maximum amount is equal to the lesser of:
   a. The amount of insurance that terminated under this policy; or
   b. $100,000.00.
2. The minimum amount is $2,500.00.

This amount is subject to any reductions due to age that may be contained in the portable group term life insurance policy.

Exclusions

Applicable to optional insurance
No benefits are payable for any loss for death that results from, is contributed to or caused by:

1. Suicide, committed while sane or insane, occurring within 24 months after the covered person's initial effective date of insurance with the Sponsor; and
2. Suicide, committed while sane or insane, occurring within 24 months after the date any additional insurance elected by the covered person becomes effective under this policy.

The suicide exclusion will apply to any amounts of insurance for which the covered person pays all or part of the premium.

The suicide exclusion will also apply to any amount that is subject to evidence of insurability Lincoln approved.

Accidental death and dismemberment exclusions
No benefits are payable for any loss that is contributed to or caused by:

1. War, declared or undeclared, or any act of war;
2. Intentionally self-inflicted injuries, while sane or insane;
3. Suicide, or suicide attempt, while sane or insane;
4. Active participation in a riot;

5. Committing or attempting to commit a felony or misdemeanor;
6. Disease, bodily or mental illness (or medical or surgical treatment thereof);
7. Infections, except septic infections of and through a visible wound;
8. Controlled substances (as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments) that are voluntarily taken, ingested or injected, unless as prescribed or administered by a physician;
9. Serving full-time active duty in the Armed Forces of any country or international authority;
10. Boarding, leaving or being in or on any kind of aircraft. However, this exclusion will not apply if the covered person is a fare paying passenger on a commercial aircraft or traveling as a passenger or working as a pilot or a crew member in any aircraft that is owned or leased by or on behalf of the Sponsor; or
11. The presence of alcohol in the covered person's blood which raises a presumption that the covered person was under the influence of alcohol and contributed to the cause of the accident. The blood alcohol level is governed by the jurisdiction of the state in which the accident occurred; or
12. Hazardous sports, including but not limited to, motor sports (land or water), mountain climbing, skydiving, parachuting, bungee jumping, hang gliding and scuba diving

No benefit will be payable for any loss suffered as a result of accidental injury during any period of incarceration.

With respect to this provision, "participation" shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the Covered Person, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to police officers and fire fighters.

With respect to this provision, "riot" shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

Termination provisions

Termination of a covered person's insurance

A covered person will cease to be insured on the earliest of the following dates:
1. The date this policy terminates, but without prejudice to any claim originating prior to the time of termination;
2. The date the covered employee is no longer in an eligible class;
3. The date the covered employee's class is no longer included for insurance;
4. The last day for which any required employee contribution has been made;
5. The date employment (status as an active employee) or eligibility ends for any reason; or
6. The date the covered employee ceases to be in active employment due to a labor dispute, including any strike, work slowdown, or lockout.

Lincoln reserves the right to review and terminate all classes insured under this policy if any class(es) cease(s) to be covered.

Termination

1. Termination of this policy under any conditions will not prejudice any payable claim which occurs while this policy is in force.
2. If the Sponsor fails to pay any premium within the grace period, this policy will terminate at 12:00 midnight Standard Time on the last day of the grace period. The “grace period” is the 31 days following a premium due date during which premium payment may be paid.
3. The Sponsor may terminate this policy by advance written notice delivered to Lincoln at least 31 days prior to the termination date. This policy will not terminate during any period for which premium has been paid. The Sponsor will be liable to Lincoln for all premiums due and unpaid for the full period for which this policy is in force.
4. Lincoln may terminate this policy on any premium due date by giving written notice to the Sponsor at least 31 days in advance if:
   a. The number of employees insured is fewer than 10; or
   b. Less than 100% of the employees eligible for any non-contributory insurance are insured for it; or
   c. Less than 60.00% of the employees eligible for any contributory optional insurance are insured for it; or

d. The Sponsor fails:
   i. To furnish promptly any information which Lincoln may reasonably require; or
   ii. To perform any other obligations pertaining to this policy.

5. Lincoln may terminate this policy or any coverage(s) afforded hereunder and for any class of covered employees on any premium due date after it has been in force for 12 months. Lincoln will provide written notice of such termination to the Sponsor at least 31 days before the termination is effective.

6. Termination may take effect on an earlier date if agreed to by the Sponsor and Lincoln.

Appeals applicable to all claims except waiver of premium claims

Lincoln will notify in writing any covered person or beneficiary whose claim is denied in whole or part. That written notice will explain the reasons for denial. If the claimant does not agree with the reasons given, he or she may request an appeal of the claim. To do so, the claimant should write to Lincoln within 60 days after the notice of denial was received. The claimant should state why he or she believes the claim was improperly denied. Any data, questions or comments that the claimant thinks are appropriate should be included. Unless Lincoln requests additional material in a timely fashion, the claimant will be advised of Lincoln's decision within 60 days after his or her letter is received.

If your claim is denied, Lincoln's notice of denial shall include:

1. The specific reason or reasons for the denial with reference to those specific Plan provisions on which the denial is based.

2. A description of any additional material or information necessary to complete the claim and an explanation of why that material or information is necessary.

3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal.

If your claim is denied, Lincoln's notice of denial shall include:

1. Submit, for review, written comments, documents, records and other information relating to the claim to Lincoln.

2. Request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

3. A review on appeal that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision.

Lincoln will make a full and fair review of your appeal and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made within a reasonable period of time, but not later than 60 days following receipt of the written request for review, unless Lincoln determines that special circumstances require an extension. In such case, a written extension notice will be sent to you before the end of the initial 60 day period. The extension notice must indicate the special circumstances and the date by which Lincoln expects to render the appeal decision. The extension cannot exceed a period of 60 days.

The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

If your claim is denied, Lincoln's notice of denial shall include:

1. The specific reason or reasons for the denial with reference to those specific Plan provisions on which the denial is based.

2. 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 your claim.

3. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

Time frame for claim decisions

If your claim is denied, Lincoln will notify you of the adverse decision within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if Lincoln: (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the

end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, Lincoln determines, due to matters beyond the Plan's control, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days, provided Lincoln notifies you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

The notice of extension shall explain: (1) the standards on which benefit entitlement is based, (2) the unresolved issues that prevent a claim decision, and (3) the additional information needed. You have at least 45 days to provide the information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date Lincoln sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

If your claim is denied

Lincoln's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based.
2. A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary.
3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal.
4. If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, other similar criterion was relied upon and a copy thereof will be provided free of charge upon request.
5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

To appeal a claim denial

You, or your authorized representative, may appeal a denied claim within 180 days after you receive Lincoln's notice of denial. You have the right to:

1. Submit to Lincoln, for review, written comments, documents, records, and other information relating to the claim.
2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
3. A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision.
4. A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person's subordinate.
5. If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual.
6. The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.

Lincoln will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless Lincoln determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period. The extension notice shall indicate the special circumstances and the date by which Lincoln expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period.

The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

Lincoln's notice of denial shall include:
1. The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based.
2. 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 your claim.
3. A statement describing any voluntary appeal procedures offered by Lincoln and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.
4. If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request.
5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

General provisions

Assignment
The coverage under this policy is not assignable by the Sponsor without Lincoln's written consent. A covered employee may assign all of his present and future right, title, interest, and incidents of ownership of:
1. Any life insurance;
2. Any disability provision of life insurance; and
3. Any Accidental Death and Dismemberment Insurance under this policy.

Such assignment will include, but is not limited to, the rights:
1. To make any contribution required to keep the coverage in force;
2. To exercise any conversion privilege; and
3. To change the beneficiary.

Beneficiary
Each covered employee must name a beneficiary to whom the insurance benefits under this policy are payable. If more than one beneficiary is named and if their interests are not specified, any surviving beneficiaries will share equally. For any dependent life insurance, the covered employee is automatically designated as the beneficiary.

If, at the death of a covered employee, there is no named or surviving beneficiary, Lincoln will pay the benefits to the executor or administrator of the covered employee's estate. Lincoln may, at its option, pay the benefits to a surviving relative in the following order: spouse, child, parent, sibling. Such payment will release Lincoln of all further liability to the extent of payment.

A covered employee may change his beneficiary at any time by written request. Lincoln or the Sponsor will provide a form for that purpose. Any change of beneficiary will take effect when the Sponsor receives the written request whether or not the covered employee is alive at that time. Such change will relate back to the date of the request. Any change of beneficiary will not apply to any payment made before the request was received by the Sponsor.

Conformity with state statutes
Any provision of this policy which, on its effective date, is in conflict with the statutes of the governing jurisdiction of this policy is hereby amended to conform to the minimum requirements of such statute.

Employee's Certificate
Lincoln will provide a Certificate to the Sponsor for delivery to covered employees. It will state:
1. The name of the insurance company and the policy number;
2. A description of the insurance provided;

3. The method used to determine the amount of benefits;
4. To whom benefits are payable;
5. Limitations or reductions that may apply;
6. The circumstances under which insurance terminates; and
7. The rights of the covered person upon termination of this policy.

If the terms of a Certificate and this policy differ, this policy will govern.

Entire contract – policy changes

1. This policy is the entire contract. It consists of:
   a. All of the pages;
   b. The attached signed application of the Sponsor; and
   c. If contributory each employee's signed application for insurance.
2. This policy may be changed in whole or in part. Only an officer of Lincoln can approve a change to the policy. The approval must be in writing and endorsed on or attached to this policy.
3. No other person, including an agent, may change this policy or waive any part of it.

Examination

Lincoln, at its own expense, has the right and opportunity to have a covered person, whose injury or sickness is the basis of a claim, examined or evaluated at reasonable intervals deemed necessary by Lincoln. This right may be used as often as reasonably required. Lincoln may also require an autopsy unless prohibited by law.

Facility of payment

If a beneficiary or covered person is a minor or is physically or mentally incapable of giving a valid release for payment, Lincoln, at its option, may make payment not to exceed $250.00 to a party who appears to have assumed responsibility for the care and support of such person. Lincoln will only make such payment until claim is made by a guardian of the estate of the beneficiary or the covered person. Such payment will release Lincoln of all further liability to the extent of payment.

Furnishing of information – access to records

1. The Sponsor will furnish at regular intervals to Lincoln:
   a. Information relative to employees:
      i. Who qualify to become insured;
      ii. Whose amounts of insurance change; and/or
      iii. Whose insurance terminates.
   b. Any other information about this policy that may be reasonably required.
      The Sponsor's records which, in the opinion of Lincoln, have a bearing on the insurance will be opened for inspection at any reasonable time.
2. Clerical error or omission will not deprive an employee of insurance.

Incontestability

This policy will not be contested, except for nonpayment of premium, after it has been in force for two years from the date of issue. The coverage of any covered person shall not be contested, except for nonpayment of premium, on the basis of a statement made relating to insurability of the covered person after such coverage has been in force for two years during the covered person's lifetime.

Any statements in any application will be deemed representations and not warranties. No representation made by:

1. The Sponsor in applying for this policy will make it void unless the representation is contained in the Sponsor’s signed application; or
2. Any covered person in enrolling for insurance under this policy will be used to reduce or deny a claim unless the representation is contained in an application signed by him and such application is given to him or his beneficiary.

Interpretation of the policy

Lincoln shall possess the authority to construe the terms of this policy and to determine benefit eligibility hereunder. Lincoln's decisions regarding construction of the terms of this policy and benefit eligibility shall be conclusive and binding.

Legal proceedings
A claimant or the claimant's authorized representative cannot start any legal action:
1. Until 60 days after proof of claim has been given; or
2. More than one year after the time proof of claim is required.

Legal actions are contingent upon first having followed the claims and appeals procedure outlined in this policy.

Misstatement of age
If a covered person's age has been misstated, an equitable adjustment will be made in the premium, benefits, or both. If the amount of the benefit is dependent upon the covered person's age, the amount of the benefit will be the amount the covered person would have been entitled to if his correct age were known.

A refund of premium will not be made for a period more than 12 months before the date Lincoln is advised of the error.

Notice and proof of claim
1. Notice
   a. Notice of claim must be given to Lincoln within 30 days of the date of the loss on which the claim is based. If that is not possible, Lincoln must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to Lincoln.
   b. When written notice of claim is applicable and has been received by Lincoln, the covered person will be sent claim forms. If the forms are not received within 15 days after written notice of claim is sent, the covered person can send to Lincoln written proof of claim without waiting for the forms.
2. Proof
   a. Satisfactory proof of loss must be given to Lincoln no later than 30 days after the date of loss.
   b. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

Lincoln reserves the right to determine if the covered person’s proof of loss is satisfactory.

Optional methods of settlement
Benefits are usually payable in one sum. However, the covered person may elect in writing to have the proceeds paid through an installment program offered by Lincoln. If the covered person makes no such election, his beneficiary may do so at the covered person's death.

Any installments remaining after the death of the payee will be paid as directed in the election of this option. Such direction is subject to the approval of Lincoln.

Lincoln Security Account
If the benefits to be paid total more than $10,000, a beneficiary may elect to have the proceeds deposited into a Lincoln Security Account. The Lincoln Security Account is an interest-bearing checking account, that is fully guaranteed by Lincoln, and the beneficiary may draw on the entire sum of the proceeds at any time. If the Lincoln Security Account is not elected, benefits may be paid in one sum.

Payment of benefits
All benefits are payable when Lincoln receives written satisfactory proof of loss. Benefits for loss of life of the covered employee are paid to the beneficiary. Benefits for loss of life of the covered dependent are paid to the covered employee. Benefits for other losses are paid to the covered employee.

Right of recovery
Lincoln has the right to recover any overpayment of benefits caused by, but not limited to, the following:
1. Fraud;
2. Any error made by Lincoln in processing a claim; or
3. Any error made in the eligibility or administration of this policy by the Sponsor.

Lincoln may recover an overpayment by, but not limited to, the following:
1. Requesting a lump sum payment of the overpaid amount;
2. Reducing any benefits payable under this policy; or
3. Taking any appropriate collection activity available including any legal action needed.

It is required that full reimbursement be made to Lincoln.

Workers' Compensation
This policy and the coverages provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

Premiums

Premium rates
Lincoln has set the premiums that apply to the coverage(s) provided under this policy. Those premiums are shown in a notice given to the Sponsor with or prior to delivery of this policy.

A change in the initial premium rate(s) will not take effect within the first 36 months except that Lincoln may change premium rates at any time for reasons which affect the risk assumed, including those reasons shown below:
1. A change occurs in the policy design;
2. A division, subsidiary or associated company is added to or deleted from this policy;
3. When the number of covered persons changes by 15.00% or more from the number insured on this policy's effective date; or
4. A change in existing law which affects this policy.

Lincoln may, upon notice to the Sponsor, set new premium rates to become effective on or at any time after the first anniversary date of this policy. However, no premium may be changed unless Lincoln notifies the Sponsor at least 31 days in advance. Premium changes may take effect on an earlier date when both Lincoln and the Sponsor agree.

Payment of premiums
1. All premiums due under this policy, including adjustments, if any, are payable by the Sponsor on or before their due dates at Lincoln's Administrative Office, or to Lincoln's agent. The due dates are specified on the first page of this policy.
2. All payments made to or by Lincoln shall be in United States dollars.
3. If premiums are payable on a monthly basis, premiums for additional or increased insurance becoming effective during a policy month will be charged from the next premium due date.
4. The premium charge for insurance terminated during a policy month will cease at the end of the policy month in which such insurance terminates. This manner of charging premium is for accounting purposes only. It will not extend insurance coverage beyond a date it would have otherwise terminated as shown in the *Termination of a covered person's insurance* provision of this policy.
5. If premiums are payable on other than a monthly basis, premiums for additional, increased, reduced or terminated insurance will cause a prorated adjustment on the next premium due date.
6. Except for fraud and premium adjustments, refunds of premiums or charges will be made only for:
   a. The current policy year; and
   b. The immediately preceding policy year.

Grace period
A grace period of 31 days will be allowed for the payment of premium after a premium due date other than the first. No interest will be charged. During this period this policy will continue in force. But, if the Sponsor gives Lincoln written notice to terminate the policy on an earlier date, then this policy will end on such earlier date. The Sponsor must pay the pro rata premium for the time the policy was in force during the grace period.

Short-term Disability (STD)

Pregnancy, a scheduled surgery or an unplanned illness or injury could keep you off the job and off the payroll for an extended period of time. Ben E. Keith's short-term disability (STD) plan protects part of your paycheck if you are unable to work due to a non-work-related sickness or injury.

What you need to know

- Your STD coverage is paid by Ben E. Keith if you are a full-time active employee who works a minimum of 30 regularly scheduled hours per week.
- If you are an hourly employee, STD benefits will begin after your 14th consecutive day of disability.
- If you are a salaried employee, STD benefits will begin on your date of disability.
- STD benefits will continue for up to a maximum of 24 weeks for hourly employees and up to a maximum of 26 weeks for salaried and commission employees.

Refer to the **Plan administration and ERISA rights** chapter for information about your rights as an STD Plan participant.

To find:	Go to or call:
Online version of this **Short-term Disability** chapter	bek.family under the **Resources** section, accessible through the menu
Appy for Short-term Disability	mylincolnportal.com using Company code **BEKCO** or call 1-888-408-7300

Eligibility

Active, full-time employees who work a minimum of 30 regularly scheduled hours per week automatically receive short-term disability coverage. Refer to the **Eligibility and enrollment** chapter to learn more.

STD does not cover temporary or seasonal employees, or employees who are not legal residents working in the United States.

Eligibility date for benefits

If you are in an eligible class you will qualify for benefits on the later of:

1. This Plan's effective date; or
2. The day after you complete the eligibility waiting period.

What happens to your benefits during a Family and Medical leave?

Your participation may be continued under this Plan for an approved family or medical leave of absence for up to 12 weeks following the date participation would have terminated, subject to the following:

1. The authorized leave is in writing;
2. The required contribution is made;
3. Your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the date before said leave begins; and
4. Continuation of participation will cease immediately if any one of the following events should occur:
   a. You return to work;
   b. This group benefit Plan terminates;
   c. You are no longer in an eligible class;
   d. Failure to make the required contribution when due to the Company; or
   e. Your employment terminates.

When you become eligible to participate

Ben E. Keith employees are eligible to become a participant in the STD Plan on the first day of the month after he or she has completed 60 days of continuous, active employment (or 30 days of continuous, active employment for Southeast Division and Kelley Manufacturing employees) with the Company. See the **Eligibility and enrollment** chapter for additional information concerning your eligibility to participate.

Effective date of participation

An employee becomes a participant on the date he or she becomes eligible; provided however, that if an employee is not actively employed on the date that his or her participation would otherwise become effective, his or her participation will be deferred until the date on which he or she returns to active employment.

Eligibility for Benefits

Elimination period

An hourly participant who sustains a disability will, subject to the provisions of the Plan, become eligible to receive benefits as of the 15th day of disability; provided, however, that the participant has been examined by or is under the care of a physician during some portion of that period.

Benefits will begin on the first day following the completion of the elimination period. However, benefits will begin on the 1st day of continuous disability if you are hospitalized due to the same disability. Hospitalization is defined as one overnight stay in a hospital.

Disability income benefits

Amount of benefits

During the period for which a benefit is payable, the percentage of basic weekly earnings, less other income benefits and other income earnings, is shown below:

Employee classification	Benefit duration	Benefit percentage
Salaried	From 0 through 84 days From 85 to 182 days	100% 80%
Hourly	From 15 through 182 days or end of disability	60%

Maximum benefit period

The period for which a benefit is payable for injury or illness, following completion of the elimination period, for any one disability will end on the earliest of:

- The end of the disability; or
- The end of the 24th week of disability for which a benefit is payable for hourly employees; or
- The end of the 26th week of disability for which a benefit is payable for salaried and commission employees.

Disability income benefits

When disability benefits are paid

When the Plan receives proof that you are disabled due to injury or sickness and require the regular attendance of a physician, you may be eligible to receive a weekly benefit after the end of the elimination period, subject to any other provisions of this Plan. The benefit will be paid for the period of disability if you give to the Plan proof of continued:

1. Disability;
2. Regular attendance of a physician; and
3. Appropriate available treatment.

The proof must be given upon the Plan's request and at your expense. In determining whether you are disabled, the Plan will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining disability, the injury must occur and disability must begin while you are a participant of this Plan.

The weekly benefit will not:

1. Exceed your amount of benefits; or
2. Be paid for longer than the maximum benefit period.

The amount of benefits and the maximum benefit period are shown earlier in this chapter.

How the weekly disability benefit amount is calculated

To calculate the amount of weekly benefit:

1. Take the lesser of:
   a. Your basic weekly earnings multiplied by the benefit percentage shown the earlier in this chapter; or
   b. The maximum weekly benefit shown in the chart earlier in this chapter; and then
2. Deduct other income benefits and other income earnings, (shown in the other income benefits and other income earnings provision of this Plan), from this amount.

Partial disability

When the Plan receives proof that you are partially disabled and have experienced a loss of earnings due to injury or sickness and require the regular attendance of a physician, you may be eligible to receive a weekly benefit, subject to any other provisions of this Plan. To be eligible to receive partial disability benefits, you may be employed in your own job or another job, must satisfy the elimination period, and must be earning between 20.00% and 80.00% of your basic weekly earnings.

Payment of partial disability benefits

A weekly benefit will be paid for the period of partial disability if you give to the Plan proof of continued:

1. Partial disability;
2. Regular attendance of a physician; and
3. Appropriate available treatment.

The proof must be given upon the Plan's request and at your expense. In determining whether you are partially disabled, the Plan will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining partial disability, the injury must occur and partial disability must begin while you are a participant of this Plan.

Using proportionate loss calculation to determine benefits

To calculate the amount of weekly benefit a proportionate loss calculation formula (**A** divided by **B**) x **C** will be used.

- **A.** = Your basic weekly earnings minus your earnings received while you are partially disabled. This figure represents the amount of lost earnings.
- **B.** = Your basic weekly earnings.
- **C.** = The weekly benefit as figured in the disability provision of this Plan plus your earnings received while you are partially disabled (not including adjustments under the cost-of-living adjustment benefit, if included).

Other income benefits and other income earnings

What are your other income benefits and other income earnings?

Other income benefits mean:

1. The amount for which you are eligible under:
   a. Any work loss provision in mandatory "no-fault" auto coverage; or
   b. Any governmental program or coverage required or provided by statute (including any amount attributable to your family).
2. Any amount you receive from any unemployment benefits; or
3. Any amount of disability and/or retirement benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar Plan or act, which:
   a. You receive or are eligible to receive; and
   b. Your spouse, child or children receives or are eligible to receive because of your disability; or

c. Your spouse, child or children receives or are eligible to receive because of your eligibility for retirement benefits.

Other income earnings mean:
1. Any amount you receive from any formal or informal sick leave or salary continuation Plan(s); and
2. The amount of earnings you earn or receive from any form of employment.

Other income benefits, except retirement benefits, must be payable as a result of the same disability for which the Company pays a benefit. The sum of other income benefits and other income earnings will be deducted in accordance with the provisions of this Plan.

Estimation of benefits

How benefits are estimated
Your disability or partial disability benefits will be reduced by the amount of other income benefits that the Plan estimates is payable to you and your dependents.

Your disability benefit will not be reduced by the estimated amount of other income benefits if you:
1. Provide satisfactory proof of application for other income benefits;
2. Sign a reimbursement agreement under which, in part, you agree to repay the Plan for any overpayment resulting from the award or receipt of other income benefits;
3. If applicable, provide satisfactory proof that all appeals for other income benefits have been made on a timely basis to the highest administrative level unless the Plan determines that further appeals are not likely to succeed; and
4. If applicable, submit satisfactory proof that other income benefits have been denied at the highest administrative level unless the Plan determines that further appeals are not likely to succeed.

In the event that the Plan overestimates the amount payable to you from any plans referred to in the other income benefits and other income earnings provision of this Plan, the Plan will reimburse you for such amount upon receipt of written proof of the amount of other income benefits awarded (whether by compromise, settlement, award or judgement) or denied (after appeal through the highest administrative level).

If you receive a lump sum payment
Other income benefits from a compromise, settlement, award or judgement which are paid to you in a lump sum and meant to compensate you for any one or more of the following:
1. Loss of past or future wages;
2. Impaired earnings capacity;
3. Lessened ability to compete in the open labor market;
4. Any degree of permanent impairment; and
5. Any degree of loss of bodily function or capacity.

These other incomes will be prorated on a weekly basis as follows:
a. Over the period of time such benefits would have been paid if not in a lump sum; or
b. If such period of time cannot be determined, over a period of 260 weeks.

If your benefit period is less than one week
For any period for which a short-term disability benefit is payable that does not extend through a full week, the benefit will be paid on a protracted basis. The rate will be $1/5^{th}$ for each day for such period of disability.

When short-term disability benefits are discontinued
The weekly benefit will cease on the earliest of:
1. The date you fail to provide proof of continued disability or partial disability and regular attendance of a physician;
2. The date you fail to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.
3. The date you refuse to be examined or evaluated at reasonable intervals;
4. The date you refuse to receive appropriate available treatment;
5. The date you refuse a job with the Company where workplace modifications or accommodations were made to allow you to perform the material and substantial duties of the job;

6. The date you are able to work in your own job on a part-time basis, but choose not to;
7. The date your current partial disability earnings exceed 80.00% of your basic weekly earnings. Because your current earnings may fluctuate, earnings will be averaged over three consecutive weeks rather than immediately terminating your benefit once 80.00% of basic weekly earnings has been exceeded.
8. The date you are no longer disabled according to this Plan;
9. The end of the maximum benefit period; or
10. The date you die.

Successive periods of disability

If you return to work and become disabled again
With respect to this Plan, "successive periods of disability" means a disability which is related or due to the same cause(s) as a prior disability for which a weekly benefit was payable.

A successive period of disability will be treated as part of the prior disability if, after receiving disability benefits under this Plan, you:
1. Return to your own job on an active employment basis for less than fourteen continuous days; and
2. perform all the material and substantial duties of your own job.

To qualify for the successive periods of disability benefit, you must experience more than a 20% loss of basic weekly earnings.

Benefit payments will be subject to the terms of this Plan for the prior disability.

If you return to your own job on an active employment basis for fourteen continuous days or more, the successive period of disability will be treated as a new period of disability. you must complete another elimination period.

If you become eligible for benefits under any other group short-term disability plan, this successive period of disability provision will cease to apply to you.

Exclusions

Disabilities not covered
No participant will be entitled to a benefit under this Plan due to:
1. War, declared or undeclared, or any act of war;
2. Intentionally self-inflicted injuries, while sane or insane;
3. Active participation in a riot;
4. The committing of or attempting to commit an indictable offense;
5. Cosmetic surgery unless such surgery is in connection with an injury or sickness sustained while the individual is an employee; or
6. A gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change.

No benefit will be payable during any period of incarceration.

With respect to this provision, participation shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of you, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to police officers and fire fighters.

With respect to this provision, riot shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

Disability benefit exclusions
A weekly benefit will not be payable if you become disabled due to:
1. Injury that arises out of or in the course of employment; or
2. Sickness when a benefit is payable under a Workers' Compensation law, or any other act or law of like intent.

When benefits end

You will automatically cease to be covered on the earliest of the following dates:

1. The date this Plan terminates, but without prejudice to any claim originating prior to the time of termination;
2. The date you are no longer in an eligible class;
3. The date your class is no longer included for benefits;
4. The date employment terminates. Cessation of active employment will be deemed termination of employment, except the insurance will be continued for an employee absent due to disability during the elimination period;
5. The date you cease active work due to a labor dispute, including any strike, work slowdown, or lockout; or
6. The date of any other termination event specified in the **Eligibility and enrollment** chapter.

General provisions

Assignment

No assignment (an agreement that transfers the insurance claims rights or benefits of the policy to a third-party) of any present or future right or benefit under this Plan will be allowed.

Examination rights

The Plan may have the right and opportunity to have you, whose injury or sickness is the basis of a claim, examined or evaluated at reasonable intervals deemed necessary by the Plan. This right may be used as often as reasonably required.

Legal proceedings

A claimant or the claimant's authorized representative cannot start any legal action:

1. Until 60 days after proof of claim has been given; or
2. More than one year after the time proof of claim is required.

Notifying Lincoln of a claim

a. Notice of claim must be given to the Plan within 30 days of the date of the loss on which the claim is based. If that is not possible, Lincoln, on behalf of the Company, must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to the Plan.
b. When written notice of claim is applicable and has been received by the Plan you will be sent claim forms. If the forms are not received within 15 days after written notice of claim is sent, you can send to the Plan written proof of claim without waiting for the forms.

Proof of claim

a. You must provide Lincoln with satisfactory proof of loss no later than 30 days after the end of the elimination period.
b. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.
c. Proof of continued loss, continued disability or partial disability, when applicable, and regular attendance of a physician must be given to the Plan within 30 days of the request for such proof.

The Plan reserves the right to determine if your proof of loss is satisfactory.

Rights of recovery

The Company has the right to recover any overpayment of benefits caused by, but not limited to, the following:

1. Fraud;
2. Any error made by the Company in processing a claim; or
3. Your receipt of any other income benefits.

The Company may recover an overpayment by, but not limited to, the following:

1. Requesting a lump sum payment of the overpaid amount;
2. Reducing any benefits payable under this Plan;
3. Taking any appropriate collection activity available including any legal action needed; and
4. Placing a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income benefits, whether on a periodic or lump sum basis.

It is required that full reimbursement be made to the Plan.

Rights of subrogation and reimbursement

When your injury appears to be someone else's fault, benefits otherwise payable under this Plan for loss of time as a result of that injury will not be paid unless you or your legal representative agree(s):

1. To repay the Plan, for such benefits to the extent they are for losses for which compensation is paid to you by or on behalf of the person at fault;
2. To allow the Plan, a lien on such compensation and to hold such compensation in trust for the Plan; and
3. To execute and give to the Plan, any instruments needed to secure the rights under 1. and 2. above.

Further, when the Company has paid benefits to or on behalf of the injured covered person, the Company will be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount the Company has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Plan.

Workers' Compensation

This Plan and the benefits provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation law or other similar law.

Long-term Disability (LTD)

Your paycheck is the foundation of your financial health. Think about how you would survive financially if you became disabled and were unable to work. Bills would keep coming, even if your paychecks stopped. Ben E. Keith's Long-term Disability (LTD) Plan protects a portion of your paycheck if you are unable to work during a disability.

What you need to know

- Your LTD coverage is paid by Ben E. Keith if you are a full-time active employee who works a minimum of 30 regularly scheduled hours per week. Refer to the **Eligibility and enrollment** chapter to learn more.
- LTD does not cover temporary or seasonal employees, or employees who are not legal residents working in the United States.
- LTD benefits will begin after your short-term disability ends.

Refer to the **Plan administration and ERISA rights** chapter for information about your rights as an LTD Plan participant.

To find:	Go to or call:
Online version of this **Long-term Disability** chapter	bek.family under the **Resources** section, accessible through the menu
Apply for Long-term Disability	mylincolnportal.com using Company code **BEKCO** or call 1-888-408-7300

When you become eligible to participate

Ben E. Keith employees are eligible to become a participant in the LTD Plan on the first day of the month after he or she has completed 60 days of continuous, active employment with the Company (or 30 days of continuous, active employment for Southeast Division and Kelley Manufacturing). See the **Eligibility and enrollment** chapter for additional information concerning your eligibility to participate.

Eligibility and effective dates

Effective date of participation

An employee becomes a participant on the date he or she becomes eligible; provided however, that if an employee is not actively employed on the date that his or her participation would otherwise become effective, his or her participation will be deferred until the date on which he or she returns to active employment.

Eligibility date for benefits

If you are in an eligible class you will qualify for benefits on the later of:

1. This Plan's effective date; or
2. The day after you complete the eligibility waiting period.

Eligibility waiting period

You are eligible to participate if you:

1. Are employed by Ben E. Keith on the Plan effective date – the first of the month coincident with or next following 60 days (30 days for Southeast Division and Kelley Manufacturing employees) of continuous, active employment; or
2. Begin employment at Ben E. Keith after the Plan effective date – the first of the month coincident with or the next following 60 days (30 days for Southeast Division and Kelley Manufacturing employees) of continuous, active employment.

Elimination period
A participant who sustains a disability will, subject to the provisions of the Plan, become eligible to receive benefits at the greater of:
1. The end of your short-term disability benefits; or
2. 180 days.

Effective date of insurance
Your insurance will be effective at 12:01 a.m. Standard Time in the governing jurisdiction on the day determined as noted, but only if your application or enrollment for insurance is made with Lincoln through the Sponsor in a form or format satisfactory to Lincoln.

You will be insured on your eligibility date.

Delay in your effective date
Your effective date of any initial, increased or additional insurance will be delayed if you are not in active employment because of injury or sickness. The initial, increased or additional insurance will begin on the date you return to active employment.

What happens to your benefits during a Family and Medical leave?
Your participation may be continued under this Plan for an approved family or medical leave of absence for up to 12 weeks following the date participation would have terminated, subject to the following:
1. The authorized leave is in writing;
2. The required contribution is made
3. Your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the date before said leave begins; and
4. Continuation of participation will cease immediately if any one of the following events should occur:
   a. You return to work;
   b. This group benefit Plan terminates;
   c. You are no longer in an eligible class;
   d. Failure to make the required contribution when due to the Company; or
   e. Your employment terminates.

If you are rehired
If you are a former employee and are re-hired by Ben E. Keith within 30 days of your termination date, all past periods of active employment with the Company will be used in determining your eligibility date. If you are a former employee and are re-hired by Ben E. Keith more than 30 days after your termination date, you are considered to be a new employee when determining your eligibility date

What happens during a leave of absence?
Ben E. Keith may continue your coverage(s) by paying the required premiums, if you are given a leave of absence.

Your coverage will not continue beyond the end of the policy month following the policy month in which the leave of absence begins. In continuing such coverage under this provision, the Company agrees to treat all covered employees equally.

If a layoff occurs
Ben E. Keith may continue your coverage(s) by paying the required premiums, if you are temporarily laid off.

Your coverage will not continue beyond the end of the policy month following the policy month in which the lay-off begins. In continuing such coverage under this provision, Ben E. Keith agrees to treat all covered Employees equally.

Transfer of insurance carriers
In order to prevent loss of coverage for you because of transfer of insurance carriers, this Plan will provide coverage for you as follows:

If you are not actively employed due to injury or sickness
Subject to premium payments, this Plan will cover you if:
1. At the time of transfer, you were covered under the prior carrier's plan; and
2. You are not in active employment due to injury or sickness on the effective date of this Plan.

Benefits will be determined based on the lesser of:

1. The amount of the disability benefit that would have been payable under the prior plan and subject to any applicable Plan limitations; or
2. The amount of disability benefits payable under this Plan. If benefits are payable under the prior plan for the disability, no benefits are payable under this Plan.

If you are disabled due to a pre-existing condition

If you were insured under the prior carrier's plan at the time of transfer and were in active employment and insured under this Plan on its effective date, benefits may be payable for a disability due to a pre-existing condition.

If you can satisfy this Plan’s pre-existing condition exclusion, the benefit will be determined according to this Plan.
If you cannot satisfy this Plan’s pre-existing condition exclusion, then:

1. Lincoln will apply the pre-existing condition exclusion of the prior carrier's plan; and
2. If you would have satisfied the prior carrier's pre-existing condition exclusion, giving consideration towards continuous time coverage under this Plan and the prior carrier's plan, the benefit will be determined according to this Plan. However, the maximum monthly benefit amount payable under this Plan shall not exceed the maximum monthly benefit payable under the prior carrier's plan.

No benefit will be paid if you cannot satisfy the pre-existing condition exclusions of either plan.

Labor dispute

If your coverage under the policy ends because you stop active work as a result of a labor dispute, you may have the right to have continued coverage. To continue coverage, the required premium must be paid when due.

To qualify for continued coverage, you must have been covered by the policy on the date of cessation of work.

If any premium was due prior to the date of cessation of work and is unpaid at the date of cessation of work, continuation may be contingent upon payment of such premium.

Benefits under continued coverage. This continued coverage will at all times provide the same benefits as would have been afforded to you had the work cessation not occurred. This includes any changes in the coverage under this policy as may become effective while continued coverage is in effect.

Termination of continued coverage. Your continued coverage under this provision will end at the earliest of these dates:

- The date which ends the "maximum period" as defined below;
- The date ending the last period for which you have made any required payment for continued coverage on a timely basis;
- The date work cessation ends;
- The date on which the number of persons for which premium is paid is less than 75% of those eligible to continue coverage;
- The date you take full-time employment with another employer.

The "maximum period" referred to above will start with the first day of the period of work cessation and will end with the date 6 months after the work cessation began

Disability income benefits

Amount of benefits

During the period for which a benefit is payable, the percentage of basic weekly earnings, less other income benefits and other income earnings, is shown below. Refer to the table on the following page for information about the duration of your benefit, based on your age.

Employee classification	Eligibility waiting period	Benefit percentage*
Active, full-time BEK employees including salaried and commissioned employees	**1.** If you are employed by Ben E. Keith on the Plan effective date – the 1st day of the month coincident with or next following 60 days of continuous, active employment. **2.** If you begin employment for Ben E. Keith after the Plan effective date – the 1st day of the month coincident with or next following 60 days of continuous, active employment.	60% of your basic monthly earnings not to exceed a maximum monthly benefit, less other income benefits and other incomes earnings
Active, full time Southeast Division and Kelley Manufacturing employees including salaried and commissioned employees	**1.** If you are employed by Ben E. Keith on the Plan effective date – the 1st day of the month coincident with or next following 30 days of continuous, active employment. **2.** If you begin employment for Ben E. Keith after the Plan effective date – the 1st day of the month coincident with or next following 30 days of continuous, active employment.	60% of your basic monthly earnings not to exceed a maximum monthly benefit, less other income benefits and other incomes earnings
Active, full-time hourly BEK employees	**1.** If you are employed by Ben E. Keith on the Plan effective date – the 1st day of the month coincident with or next following 60 days of continuous, active employment. **2.** If you begin employment for Ben E. Keith after the Plan effective date – the 1st day of the month coincident with or next following 60 days of continuous, active employment.	60% of your basic monthly earnings not to exceed a maximum monthly benefit, less other income benefits and other incomes earnings
Active, full-time hourly Southeast Division and Kelley Manufacturing employees	**1.** If you are employed by Ben E. Keith on the Plan effective date – the 1st day of the month coincident with or next following 30 days of continuous, active employment. **2.** If you begin employment for Ben E. Keith after the Plan effective date – the 1st day of the month coincident with or next following 30 days of continuous, active employment.	60% of your basic monthly earnings not to exceed a maximum monthly benefit, less other income benefits and other incomes earnings

*Maximum basic monthly earnings vary depending on employee classification. Contact Lincoln Financial Group to apply for or to learn more about LTD benefits.

"Own occupation" duration

"Own occupation" means your occupation that you were performing when your disability or partial disability began. For the purposes of determining disability under this Plan, Lincoln will consider your occupation as it is normally performed in the national economy.

Minimum monthly benefit

The minimum monthly benefit is $100.00 or 10.00% of your gross monthly benefit, whichever is greater.

Maximum benefit period

Age at disability	Maximum benefit period
Less than age 60	To age 65 (but not less than 5 years)
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Disability benefit

When disability benefits are payable
When Lincoln receives proof that you are disabled due to injury or sickness and require the regular attendance of a physician, Lincoln will pay you a monthly benefit after the end of the elimination period, subject to any other provisions of this Plan. The benefit will be paid for the period of disability if you give to Lincoln proof of continued:
1. Disability;
2. Regular attendance of a physician; and
3. Appropriate available treatment.

The proof must be given upon Lincoln's request and at your expense. In determining whether you are disabled, Lincoln will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining disability, the injury must occur and disability must begin while you are insured for this coverage.

The monthly benefit will not:
1. Exceed your amount of insurance; or
2. Be paid for longer than the maximum benefit period.

The amount of insurance and the maximum benefit period are shown on the first page of this chapter.

How the amount of your monthly disability benefit is calculated
To figure the amount of your monthly benefit:
1. Take the lesser of:
   a. Your basic monthly earnings multiplied by the benefit percentage shown in the *Amount of benefits* chart found earlier in this chapter; or
   b. The *Maximum monthly benefit* chart shown previously in this chapter; and then
2. Deduct other income benefits and other income earnings, (shown in the *Other income benefits and other income earnings* provision section later in this chapter), from this amount.

The monthly benefit payable will not be less than the amount shown in the *Minimum monthly benefit* section of this chapter. However, if an overpayment is due to Lincoln, the minimum monthly benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

When a partial disability benefit is payable
When Lincoln receives proof that you are partially disabled and have experienced a loss of earnings due to injury or sickness and require the regular attendance of a physician, you may be eligible to receive a monthly benefit, subject to any other provisions of this Plan. To be eligible to receive partial disability benefits, you may be employed in your own occupation or another occupation, must satisfy the elimination period and must be earning between 20.00% and 80.00% of your basic monthly earnings.

A monthly benefit will be paid for the period of partial disability if you provide Lincoln with proof of continued:
1. Partial disability;
2. Regular attendance of a physician; and
3. Appropriate available treatment.

The proof must be given upon Lincoln's request and at your expense. In determining whether you are partially disabled, Lincoln will not consider employment factors including, but not limited to, interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing and loss of a professional or occupational license or certification.

For purposes of determining partial disability, the injury must occur and partial disability must begin while you are insured for this coverage.

Use of proportionate loss calculation to determine partial disability benefits
For the first 12 months, the work incentive benefit will be an amount equal to your basic monthly earnings multiplied by the benefit percentage shown in the *Amount of benefits* chart found earlier in this chapter, without any reductions from earnings. The work incentive benefit will only be reduced, if the monthly benefit payable plus any earnings exceeds 100% of your basic monthly earnings. If the combined total is more, the monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings does not exceed 100% of your basic monthly earnings.

Thereafter, to figure the amount of monthly benefit the formula (A divided by B) x C will be used.
A. = Your basic monthly earnings minus your earnings received while you are partially disabled. This figure represents the amount of lost earnings
B. = Your basic monthly earnings.
C. = The monthly benefit as figured in the disability provision of this Plan plus your earnings received while you are partially disabled, (but, not including adjustments under the Cost-of-Living Adjustment Benefit, if included).

On the first anniversary of benefit payments and each anniversary thereafter, for the purpose of calculating the benefit, the term "basic monthly earnings" is:
1. Replaced by "indexed basic monthly earnings"; and
2. Increased annually by 10.00%, or the current annual percentage increase in the Consumer Price Index, whichever is less.

The monthly benefit payable will not be less than the amount shown in the *Minimum monthly benefit* section of this chapter. However, if an overpayment is due to Lincoln, the minimum monthly benefit otherwise payable under this provision will be applied toward satisfying the overpayment.

Limitations apply for mental Illness and/or substance abuse and/or non-verifiable symptoms
The benefit for disability due to mental illness and/or substance abuse and/or non-verifiable symptoms will not exceed a combined period of 24 months of monthly benefit payments while you are insured under this Plan.

If you are in a hospital or institution for mental illness and/or substance abuse at the end of the combined period of 24 months, the monthly benefit will be paid during the confinement.

If you are not confined in a hospital or institution for mental illness and/or substance abuse, but are fully participating in an extended treatment plan for the condition that caused disability, the monthly benefit will be payable to you for up to a combined period of 36 months.

In no event will the monthly benefit be payable beyond the *Maximum benefit period* section of this chapter.

Rehabilitation incentive benefit
Lincoln will pay an increased monthly benefit while you are fully participating in a rehabilitation program. Lincoln must first approve the rehabilitation program in writing before you can be considered for this benefit. If Lincoln does not approve a rehabilitation program, the regular disability benefit will be payable provided you are disabled under the terms of this Plan. To be eligible for a rehabilitation incentive benefit, you must:
1. Be disabled and receiving benefits under this Plan; and
2. Be fully participating in a rehabilitation program approved by Lincoln.

Increased monthly benefit
If you are eligible for a rehabilitation incentive benefit, the benefit percentage, shown in the chart on the first page of this SPD, will be increased by 10.00%. The increased benefit will begin on the first day of the month after Lincoln receives written proof of your full participation in the rehabilitation program.

When disability benefits terminate
If you, at any time, decline to fully participate in an approved rehabilitation program recommended by Lincoln, your disability benefits will terminate on the first day of the month following your declination to fully participate in the approved rehabilitation program. If Lincoln recommends rehabilitation, no benefit will be paid from the date recommendation is made until Lincoln receives your written agreement to fully participate in the rehabilitation program.

When rehabilitation incentive benefits are discontinued
The rehabilitation incentive benefit will cease:
1. When you are no longer fully participating in a rehabilitation program approved by Lincoln;
2. In accordance with the provision[s] entitled *When will your long-term disability benefit be discontinued?* or
3. When the rehabilitation program ends.

For the purpose of this provision, "rehabilitation program" means a comprehensive individually tailored, goal-oriented program to return you, if you are disabled, to gainful employment. The services offered may include, but are not limited to, the following:
1. Physical therapy.
2. Occupational therapy.
3. Work hardening programs.
4. Functional capacity evaluations.
5. Psychological and vocational counseling.
6. Rehabilitative employment.
7. Vocational rehabilitation services.

Three-month survivor benefit: what happens if you die
Lincoln will pay a lump sum benefit to the eligible survivor when proof is received that you died:
1. After disability had continued for 180 or more consecutive days; and
2. While receiving a monthly benefit.

The lump sum benefit will be an amount equal to three times your last monthly benefit.

If the survivor benefit is payable to your children, payment will be made in equal shares to the children, including step children and legally adopted children. However, if any of said children are minors or incapacitated, payment will be made on their behalf to the court appointed guardian of the children's property. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

If there is no eligible survivor, the benefit is payable to the estate.

If an overpayment is due to Lincoln at the time of your death, the benefit payable under this provision will be applied toward satisfying the overpayment.

Workplace modification benefit
If you are disabled or partially disabled and receiving a benefit from Lincoln, a benefit may be payable to the Sponsor as part of your benefit for modifications to the workplace to accommodate your return to work or to assist you in remaining at work.

Lincoln will reimburse the Sponsor for up to 100% of reasonable costs the Sponsor incurs for the modification, up to the greater of:

1. $1,000.00; or
2. The equivalent of 2 months of your monthly benefit.

To qualify for this benefit:

1. The disability or partial disability must prevent you from performing some or all of the material and substantial duties of your occupation; and
2. Any proposed modifications must be approved in writing and signed by you, the Sponsor and Lincoln; and
3. The Sponsor must agree to make the modifications to the workplace to reasonably accommodate your return to work or to assist you in remaining at work.

The Sponsor's costs for the approved modifications will be reimbursed after:

1. The proposed modifications have been made; and
2. Written proof of the expenses incurred by the Sponsor has been provided to Lincoln; and
3. Lincoln has received proof that you have returned to and/or remain at work.

Other income benefits and other income earnings

Other income benefits mean:

1. The amount for which you are eligible under:
   - **a.** Workers' or Workmen's Compensation Laws.
   - **b.** Occupational Disease Law.
   - **c.** Title 46, United States Code Section 688 (The Jones Act).
   - **d.** Any work loss provision in mandatory "no-fault" auto insurance.
   - **e.** Railroad Retirement Act.
   - **f.** Any governmental compulsory benefit act or law.
   - **g.** Any other act or law of like intent.
2. The amount of any disability benefits which you are eligible to receive under:
   - **a.** Any other group insurance plan of the Sponsor.
   - **b.** Any governmental retirement system as a result of your employment with the Sponsor.
   - **c.** Any individual disability income plan where the premium is wholly or partially paid by the Sponsor. However, Lincoln will only reduce the monthly benefit if your monthly benefit under this Plan, plus any benefits that you are eligible to receive under such individual insurance plan exceed 100% of your basic monthly earnings. If this sum exceeds 100% of basic monthly earnings, your monthly benefit under this Plan will be reduced by such excess amount.
3. The amount of benefits you receive under the Sponsor's retirement plan as follows:
   - **a.** The amount of any disability benefits under a retirement plan, or retirement benefits under a retirement plan you voluntarily elect to receive as retirement payment under the Sponsor's retirement plan; and
   - **b.** The amount you receive as retirement payments when you reach the later of age 62, or normal retirement age as defined in the Sponsor's plan.
4. The amount of disability and/or retirement benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act, which:
   - **a.** You receive or are eligible to receive; and
   - **b.** Your spouse, child or children receive or are eligible to receive because of your disability; or
   - **c.** Your spouse, child or children receive or are eligible to receive because of your eligibility for retirement benefits.
5. Any amount you receive from any unemployment benefits.

Definition of “other income earnings”

1. The amount of earnings you earn or receive from any form of employment including severance; and
2. Any amount you receive from any formal or informal sick leave or salary continuation plan(s).

Other income benefits, except retirement benefits, must be payable as a result of the same disability for which Lincoln pays a benefit. The sum of other income benefits and other income earnings will be deducted in accordance with the provisions of this policy

How your benefits will be estimated
Lincoln will reduce your disability or partial disability benefits by the amount of other income benefits that we estimate are payable to you and your dependents.

Your disability benefit will not be reduced by the estimated amount of other income benefits if you:
1. Provide satisfactory proof of application for other income benefits;
2. Sign a reimbursement agreement under which, in part, you agree to repay Lincoln for any overpayment resulting from the award or receipt of other income benefits;
3. If applicable, provide satisfactory proof that all appeals for other income benefits have been made on a timely basis to the highest administrative level unless Lincoln determines that further appeals are not likely to succeed; and
4. If applicable, submit satisfactory proof that other income benefits have been denied at the highest administrative level unless Lincoln determines that further appeals are not likely to succeed.

Lincoln will not estimate or reduce for any benefits under the Sponsor's pension or retirement benefit plan according to applicable law, until you actually receive them.

In the event that Lincoln overestimates the amount payable to you from any plans referred to in the other income benefits and other income earnings provision of this Plan, Lincoln will reimburse you for such amount upon receipt of written proof of the amount of other income benefits awarded (whether by compromise, settlement, award or judgement) or denied (after appeal through the highest administrative level).

When Lincoln may provide Social Security assistance
Lincoln may help you in applying for Social Security disability income benefits. In order to be eligible for assistance you must be receiving a monthly benefit from Lincoln. Such assistance will be provided only if Lincoln determines that assistance would be beneficial.

If you receive a lump sum payment
Other income benefits from a compromise, settlement, award or judgement which are paid to you in a lump sum and are meant to compensate you for any one or more of the following:
1. Loss of past or future wages;
2. Impaired earnings capacity;
3. Lessened ability to compete in the open labor market;
4. Any degree of permanent impairment; and
5. Any degree of loss of bodily function or capacity; will be prorated on a monthly basis as follows:
   a. Over the period of time such benefits would have been paid if not in a lump sum; or
   b. If such period of time cannot be determined, the lesser of:
      i. The remainder of the maximum benefit period; or
      ii. 5 years.

If you receive any cost-of-living increases
After the first deduction for each of the other income benefits, the monthly benefit will not be further reduced due to any cost of living increases payable under the other income benefits and other income earnings provision of this Plan. This provision does not apply to increases received from any form of employment.

If your benefit period is less than a month
For any period for which a long-term disability benefit is payable that does not extend through a full month, the benefit will be paid on a prorated basis. The rate will be $1/30^{th}$ for each day for such period of disability.

When long-term disability benefits are discontinued
The monthly benefit will cease on the earliest of:
1. The date you fail to provide proof of continued disability or partial disability and regular attendance of a physician;
2. The date you fail to cooperate in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
3. The date you refuse to be examined or evaluated at reasonable intervals;
4. The date you refuse to receive appropriate available treatment;
5. The date you refuse a job with Ben E. Keith Company where workplace modifications or accommodations were made to allow you to perform the material and substantial duties of the job;

6. The date you are able to work in your own occupation on a part-time basis, but choose not to;
7. On the first day of the month following the date you refuse to fully participate in a rehabilitation program recommended by Lincoln according to the individually written rehabilitation program;
8. The date your current partial disability earnings exceed 80.00% of your indexed basic monthly earnings;

   Because your current earnings may fluctuate, Lincoln will average earnings over three consecutive months rather than immediately terminating your benefit once 80.00% of indexed basic monthly earnings has been exceeded.

9. The date you are no longer disabled according to this Plan;
10. The end of the maximum benefit period; or
11. The date you die.

If you return to work and become disabled again
With respect to this Plan, "successive periods of disability" means a disability which is related or due to the same cause(s) as a prior disability for which a monthly benefit was payable.

A successive period of disability will be treated as part of the prior disability if, after receiving disability benefits under this Plan, you:
1. Return to your own occupation on an active employment basis for less than six continuous months; and
2. Perform all the material and substantial duties of your own occupation.

To qualify for the successive periods of disability benefit, you must experience more than a 20% loss of basic monthly earnings.

Benefit payments will be subject to the terms of this Plan for the prior disability.

If you return to your own occupation on an active employment basis for six continuous months or more, the successive period of disability will be treated as a new period of disability. you must complete another elimination period.

If you become eligible for coverage under any other group long term disability coverage, these successive periods of disability provision will cease to apply to you.

General exclusions

Disabilities that are not covered
This Plan will not cover any disability due to:
1. War, declared or undeclared, or any act of war;
2. Intentionally self-inflicted injuries, while sane or insane;
3. Active participation in a riot;
4. The committing of or attempting to commit a felony or misdemeanor;
5. Cosmetic surgery unless such surgery is in connection with an injury or sickness sustained while you are covered under this Plan; or
6. A gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change.

No benefit will be payable during any period of incarceration.

With respect to this provision, *participation* shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in your defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to police officers and fire fighters.

With respect to this provision, *riot* shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

Pre-existing condition exclusion
This Plan will not cover any disability or partial disability:
1. Which is caused or contributed to by, or results from, a pre-existing condition; and
2. Which begins in the first 12 months immediately after your effective date of coverage.

"Pre-existing condition" means a condition resulting from an injury or sickness for which you were diagnosed or received treatment within three months prior to your effective date of coverage.

When your insurance ends

You will cease to be insured on the earliest of the following dates:

1. The date this Plan terminates, but without prejudice to any claim originating prior to the time of termination;
2. The date you are no longer in an eligible class;
3. The date your class is no longer included for insurance;
4. The date employment terminates. Cessation of active employment will be deemed termination of employment, except the insurance will be continued for an employee absent due to disability during:
   a. The elimination period; and
   b. Any period during which premium is being waived.
5. The date you cease active work due to a labor dispute, including any strike, work slowdown, or lockout.

Lincoln reserves the right to review and terminate all classes insured under this Plan if any class(es) cease(s) to be covered.

Assignment of benefits

No assignment (an agreement that transfers the insurance claims rights or benefits of the policy to a third-party) of any present or future right or benefit under this policy will be allowed.

Conforming with state statutes

Any provision of this Plan which, on its effective date, is in conflict with the statutes of the governing jurisdiction of this Plan is hereby amended to conform to the minimum requirements of such statute.

Rights of examination

Lincoln, at its own expense, may have the right and opportunity to have the claimant, whose injury or sickness is the basis of a claim, examined or evaluated at reasonable intervals deemed necessary by Lincoln. This right may be used as often as reasonably required.

Contesting the Plan

The validity of this Plan shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of this Plan shall not be contested on the basis of a statement made relating to insurability by you after such insurance has been in force for two years during your lifetime, and shall not be contested unless the statement is contained in a written instrument signed by you. A copy of the written instrument containing the statement shall be provided to you or, if you have died or become incapacitated, to your beneficiary or personal representative.

When legal proceedings may begin

A claimant or the claimant's authorized representative cannot begin any legal action:

1. Until 60 days after proof of claim has been given; or
2. More than three years after the time proof of claim is required.

If your age is misstated

If your age has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is dependent upon your age, the amount of the benefit will be the amount you would have been entitled to if your correct age were known.

A refund of premium will not be made for a period more than 12 months before the date Lincoln is advised of the error.

When must Lincoln be notified of a claim?

1. Notice of claim must be given to Lincoln within 30 days of the date of the loss on which the claim is based. If that is not possible, Lincoln must be notified as soon as it is reasonably possible to do so. Such notice of claim must be received in a form or format satisfactory to Lincoln.
2. When written notice of claim is applicable and has been received by Lincoln, you will be sent claim forms. If the forms are not received within 15 days after written notice of claim is sent, you can send to Lincoln written proof of claim without waiting for the forms.

When must Lincoln receive proof of claim?

1. Satisfactory proof of loss must be given to Lincoln no later than 30 days after the end of the elimination period.
2. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time. Such proof must be furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time Proof is otherwise required.
3. Proof of continued loss, continued disability or partial disability, when applicable, and regular attendance of a physician must be given to Lincoln within 30 days of the request for such proof.

Lincoln reserves the right to determine if your proof of loss is satisfactory.

Who claims are paid to

The benefit is payable to you. But, if a benefit is payable to your estate, or if you are a minor, or you are not competent, Lincoln has the right to pay up to $2,000 to any of your relatives or any other person whom Lincoln considers entitled thereto by reason of having incurred expense for the maintenance, medical attendance or burial. If Lincoln in good faith pays the benefit in such a manner, any such payment shall fulfill Lincoln's responsibility for the amount paid.

What is the time frame for claim decisions?

If your claim is denied, Lincoln will notify you of the adverse decision within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if Lincoln: (1) determines the extension is necessary because of matters beyond the Plan’s control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, Lincoln determines, due to matters beyond the Plan’s control, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days, provided Lincoln notifies you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

The notice of extension shall explain: (1) the standards on which benefit entitlement is based, (2) the unresolved issues that prevent a claim decision, and (3) the additional information needed. You have at least 45 days to provide the information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date Lincoln sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

If your claim is denied

Lincoln's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based;
2. A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary;
3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal;
4. Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration;
7. A statement that you are entitled, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim; and
8. Notice in a culturally and linguistically appropriate manner.

To appeal a claim denial

You, or your authorized representative, may appeal a denied claim within 180 days after you receive Lincoln's notice of denial. You have the right to:

1. Submit to Lincoln, for review, written comments, documents, records, and other information relating to the claim;
2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
3. A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision;
4. A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person’s subordinate;
5. If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual;
6. The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision; and
7. A review and reasonable opportunity to respond to any new or additional evidence considered, relied upon, or generated, or any new or additional rationale in support of an adverse decision, before an adverse decision is rendered.

Lincoln will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless Lincoln determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period.

The extension notice shall indicate the special circumstances and the date by which Lincoln expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period.

The appeal time frames begin when an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

Lincoln's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
2. 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 your claim;
3. A statement describing any voluntary appeal procedures offered by Lincoln and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA, including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires;
4. Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration; and
7. Notice in a culturally and linguistically appropriate manner.

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Lincoln's rights of recovery
Lincoln has the right to recover any overpayment of benefits caused by, but not limited to, the following:
1. Fraud;
2. Any error made by Lincoln in processing a claim; or
3. Your receipt of any other income benefits.

Lincoln may recover an overpayment by, but not limited to, the following:
1. Requesting a lump sum payment of the overpaid amount;
2. Reducing any benefits payable under this policy;
3. Taking any appropriate collection activity available including any legal action needed; and
4. Placing a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income benefits, whether on a periodic or lump sum basis.

It is required that full reimbursement be made to Lincoln.

How statements made in your application affect your coverage
In the absence of fraud, all statements made in any application are considered representations and not warranties (absolute guarantees). No representation by:
1. The Sponsor in applying for this Plan will make it void unless the representation is contained in the signed application; or
2. You in enrolling for insurance under this Plan will be used to reduce or deny a claim unless a copy of the enrollment form, signed by you if required, is or has been given to you.

Lincoln's rights of subrogation and reimbursement
When your injury or sickness appears to be someone else's fault, benefits otherwise payable under this Plan for loss of time as a result of that injury or sickness will not be paid unless you or your legal representative agree(s):
1. To repay Lincoln for such benefits to the extent they are for losses for which compensation is paid to you by or on behalf of the person at fault; and
2. To execute and give to Lincoln any instruments needed to secure the rights under **1.** above.

Further, when Lincoln has paid benefits to or on your behalf, Lincoln will be subrogated to all rights of recovery that you have against the person at fault. These subrogation rights will extend only to recovery of the amount Lincoln has paid. You must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to Lincoln.

How the policy affects Workers' Compensation
This Plan and the coverages provided are not in lieu of, nor will they affect any requirements for coverage under any Workers' Compensation Law or other similar law.

Amendment of Lincoln's policy:
The policy may be changed in whole or in part by mutual agreement of Ben E. Keith Company and Lincoln. Only an officer of Lincoln can approve a change. The approval must be in writing and endorsed on or attached to the policy. No consent of any participant or any other person referred to in the policy(ies) shall be required to modify, amend, or change the policy(ies).

IMPORTANT NOTE: If you cease active employment, see your benefits administrator to determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active employment.

When the policy may terminate
1. If Ben E. Keith fails to pay any premium within the grace period, the policy will automatically terminate at 12:00 midnight of the last day of the grace period. The "grace period" is the 60 days following a premium due date during which premium payment may be paid.
2. Ben E. Keith may terminate the policy by advance written notice delivered to Lincoln at least 31 days prior to the termination date. But the policy will not terminate during any period for which premium has been paid.
3. Lincoln may terminate the policy on any premium due date by giving written notice to Ben E. Keith at least 31 days in advance if:
   a. The number of employees insured is less than 10;

b. Less than 100% of the employees eligible for any non-contributory insurance are insured for it; or
c. Ben E. Keith fails:
  i. To furnish promptly any information which Lincoln may reasonably require; or
  ii. To perform any other obligations pertaining to this policy.

4. Termination may take effect on any earlier date when both Ben E. Keith and Lincoln agree.

No consent of any participant or any other person referred to in the policy(ies) shall be required to terminate the policy(ies).

Your rights in the event of policy termination
Termination of the policy under any conditions will not prejudice any payable claim which occurs while the policy is in force.

Time frame for claim decisions
If your claim is denied, Lincoln will notify you of the adverse decision within a reasonable period of time, but not later than 45 days after receiving the claim. This 45-day period may be extended for up to 30 days, if Lincoln: (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, Lincoln determines, due to matters beyond the Plan's control, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days, provided Lincoln notifies you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

The notice of extension shall explain: (1) the standards on which benefit entitlement is based, (2) the unresolved issues that prevent a claim decision, and (3) the additional information needed. You have at least 45 days to provide the information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date Lincoln sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

If your claim is denied
Lincoln's notice of denial shall include:
1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based.
2. A description of any additional material or information necessary to perfect the claim and an explanation of why that material or information is necessary.
3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring a civil action under ERISA following an adverse decision on appeal.
4. Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.
6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration.
7. A statement that you are entitled, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim.
8. Notice in a culturally and linguistically appropriate manner.

To appeal a claim denial
You, or your authorized representative, may appeal a denied claim within 180 days after you receive Lincoln's notice of denial. You have the right to:
1. Submit to Lincoln, for review, written comments, documents, records, and other information relating to the claim.

2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
3. A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision.
4. A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person's subordinate.
5. If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual.
6. The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.
7. A review and reasonable opportunity to respond to any new or additional evidence considered, relied upon, or generated, or any new or additional rationale in support of an adverse decision, before an adverse decision is rendered.

Lincoln will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless Lincoln determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period.

The extension notice shall indicate the special circumstances and the date by which Lincoln expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period.

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1. The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based.
2. 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 your claim.
3. A statement describing any voluntary appeal procedures offered by Lincoln and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA, including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires.
4. Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.
6. If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration.
7. Notice in a culturally and linguistically appropriate manner.

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Employee Assistance Program

Ben E. Keith provides all employees and their families with access to an Employee Assistance Program (EAP) through ComPsych®, a GuidanceResources Company®, which includes:

- Counseling services, which can help you handle any issues you are facing by providing sensitive, confidential support.
- FinancialConnect®
- LegalConnect®
- FamilySource®

This section describes the Employee Assistance Program, including information about:

- Eligibility
- How the Employee Assistance Program (EAP) works

Eligibility

For purposes of the Employee Assistance Program (EAP), an employee is any individual who is treated by the Company as its common law employee, who is on the regular Company payroll, and whose compensation is reported by the Company on IRS Form W-2.

Full-time employees are those who are regularly scheduled to work at least 30 hours per week. Part-time employees are those who are regularly scheduled to work less than 30 hours per week.

Both full-time and part-time employees are eligible to participate on their date of hire. Temporary employees, leased employees, independent contractors, and any persons not classified as regular employees are not eligible.

As a Company employee, you and your eligible dependents can utilize the EAP, whether or not you and/or your eligible dependents are enrolled in any other Company health care benefits.

When eligibility ends*

Your and your family members' access to EAP services ends on the earliest of the following dates:

- The last day of the month in which you retire or otherwise end your employment.
- The last day of the month in which you become totally disabled, as defined by the Long-Term Disability Plan.
- The last day of the month in which you begin a leave of absence (if you are on an approved leave under the Family and Medical Leave Act (FMLA), your access to EAP services continues).
- The day the Company discontinues the program.

*EAP services will remain available during the COBRA period to any employee or dependent who loses coverage due to a qualifying event.

How the Employee Assistance Program (EAP) works

The EAP is automatically available to all eligible employees and their eligible family members. You do not need to enroll or make any contributions. The Company pays the full cost of the EAP.

The EAP is available through ComPsych®, which is staffed by experienced professionals who provide personal and confidential counseling services. These experts can help you sort through issues and develop a solution you may not have considered on your own.

The services provided through the EAP are strictly confidential. ComPsych® will not release any information about you or your family members unless you give written permission or if required by law.

When you need help

Call ComPsych® 24 hours a day, seven days a week. When you or a family member needs help, simply:

- Call 1-866-517-1267 (toll-free).
- Visit guidanceresources.com and enter the Organization Web ID **BEK**.

Counseling services

The EAP's counseling services can provide you and your family members professional counseling and referral services, an opportunity to confidentially discuss personal and family problems for guidance and problem-solving help, and quality care by professional counselors and therapists.

The EAP can help you and your eligible dependents by:

- Identifying the problem.
- Recommending the appropriate counseling therapy and/or treatment.
- Providing referrals to community service providers and treatment programs.
- Giving confidential consultation.

Contact with the EAP can be initiated in the following ways:

- Manager or supervisor referral in order to help you improve job performance.
- Direct contact by employee.

While the Company cannot require you to participate in the program, your supervisor, manager or Human Resources representative may recommend counseling. Your participation may be a condition of continued employment in cases of serious performance or behavioral problems. However, participation in the EAP does not protect you from disciplinary action, up to and including termination of employment, if you continue to exhibit unacceptable performance or behavior. Essentially, you are responsible for the successful resolution of your problem through your willingness to seek help and treatment.

FinancialConnect®

The FinancialConnect® program offers you unlimited telephone access to certified public accountants, certified financial planners, and other financial professionals who are trained and experienced in handling personal financial issues and can offer consulting on issues such as family budgeting, credit problems, tax questions, investment options, money management and retirement programs.

LegalConnect®

The LegalConnect® program provides you with unlimited telephone consultation with attorneys who are trained and dedicated to providing legal information and assistance to clients with such issues as divorce, bankruptcy, family law, real estate purchases and wills.

If you need legal representation or extended assistance that cannot be provided by phone, LegalConnect® professionals can provide referrals to local attorneys. You or your family member will receive a free 30-minute consultation and, thereafter, a 25% reduction in fees for representation if you choose one of ComPsych's network attorneys.

FamilySource®

The FamilySource® program offers customized research, tailored educational materials and prescreened referrals for child care, adoption, elder care, education, pet care and personal convenience services.

Calling ComPsych®

When you call ComPsych®, a GuidanceResources® counselor will listen to your concerns and obtain a referral for you to talk to an expert counselor located in your area. During the appointment, the counselor will discuss your situation and help you develop a plan of action. You can visit a ComPsych® counselor up to six times at no cost to you. If it is determined that you need additional services beyond six visits, your medical plan may cover any additional care.

A ComPsych® GuidanceResources® counselor can help you deal with a variety of concerns, including:

- Depression
- Marital and family conflicts
- Drug and alcohol abuse
- Major life changes
- Relationship issues
- Anxiety and stress
- Eating disorders

Visiting GuidanceResources® online

GuidanceResources® online can help you obtain personal information for your life issues.

At GuidanceResources® online, you can:

- Obtain information about personal, emotional, and life issues.
- Read Helpsheets℠ on your topic.
- Review frequently asked questions.
- Purchase expert-endorsed products and services to support your issue or lifestyle need.
- Get book recommendations.

Remember, you'll need to enter the Company's Organization Web ID **BEK** to access the site.

If you need additional help

In cases where your situation calls for care beyond ComPsych's counseling services, the medical coverage you have through the Company can help. The benefits available depend on the medical option in which you have enrolled.

Relationship of your EAP's counseling services to other medical plans and special services

The EAP counseling services benefit is in addition to any medical coverage you have. Limited treatment services and programs may be covered under your medical option.

Please refer to the **BEK Medical Plans and prescription drugs** chapter for an explanation of the coordination of benefits provisions for any pre-certification, managed care, or notice requirements that apply to your medical option.

The BEK Retirement Savings Plan

The Ben E. Keith Company Retirement Savings Plan ("Plan") provides you with the opportunity to save for retirement on a tax-advantaged basis. This Plan includes qualified retirement plans commonly referred to as 401(k) and Profit Sharing.

This SPD describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. If the non-technical language in this SPD and the technical, legal language of the Plan document conflict, the Plan document will govern. If you wish to receive a copy of the legal Plan document, please contact Empower Retirement at empowermyretirement.com or 1-833-BEK-SAVE (1-833-235-7283).

The Plan and your rights under the Plan are subject to federal laws, such as the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, as well as certain state laws. The provisions of the Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or Department of Labor (DOL). The employer may also amend or terminate this Plan. If the Plan provisions described in this SPD change, the employer will notify you.

BEK 401(k) participation

If you are a member of a class of employees listed below, you are considered an excluded employee and you are not eligible to participate in the BEK 401(k). Excluded employees are:

- Union employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining, unless the collective bargaining agreement provides otherwise.
- Certain nonresident aliens who have no earned income from sources within the United States.
- Leased employees.
- Reclassified employees (a person the employer does not treat as a common law employee on its payroll records, such as someone paid as an independent contractor or an out-sourced worker).
- Temporary employees. However, if as a temporary employee, you complete one (1) year of service in any year of employment, you will no longer be part of this excluded class.

When you can begin to participate in the BEK 401(k)

Your entry date – the date you are allowed to enroll in the BEK 401(k) – will be the first day of the month coinciding with or next following the date you satisfy the eligibility requirements.

Participants who are eligible to make contributions to the BEK 401(k) are eligible for the safe harbor contribution described in the *Employer contributions* section later in this chapter.

Profit Sharing participation

If you are a member of a class of employees identified below, you are considered an excluded employee and are not entitled to participate in the Profit Sharing Plan. Excluded employees are:

- Union employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining, unless the collective bargaining agreement provides otherwise.
- Certain nonresident aliens who have no earned income from sources within the United States.
- Leased employees.
- Reclassified employees (a person the employer does not treat as a common law employee on its payroll records, such as someone paid as an independent contractor or an out-sourced worker).
- Temporary employees. However, if as a temporary employee, you complete one (1) year of service in any year of employment, you will no longer be part of this excluded class.
- Seasonal employees However, if as a seasonal employee, you complete one (1) year of service in any year of employment, you will no longer be part of this excluded class.

Provided you are not an excluded employee, you may begin participating in Profit Sharing and receive non-elective contributions once you have satisfied the eligibility requirements and reached your eligibility entry date. The following

section describes excluded employees (those who are not eligible to participate), the eligibility requirements and entry dates that apply. You should contact Empower Retirement if you have questions about when your participation begins.

Eligibility conditions
Full-time employees with one (1) year of Company service and part-time employees who work a minimum of 1,000 hours and have one (1) year of service are eligible to participate in Profit Sharing. However, you will actually participate in nonelective Profit Sharing contributions once you reach the entry date.

Individuals who were actively employed with Florida Food Service, Inc. immediately prior to the closing date of the acquisition of Florida Food Service, Inc. by Ben E. Keith Company and who also have one hour of service with Ben E. Keith Company immediately following the date of acquisition are considered eligible to participate in Profit Sharing.

When you become eligible to participate in Profit Sharing
Your entry date (the date you will be allowed to participate in Profit Sharing) will be the date on which you satisfy the eligibility requirements.

Excluded employees

If you are a member of a class of employees listed below, you are considered an excluded employee and are not entitled to participate in the Plan for purposes of “safe harbor” matching contributions. Refer to the *Employer Contributions* section later in this SPD for more information. Excluded employees are:

- Union employees whose employment is governed by a collective bargaining agreement under which retirement benefits were the subject of good faith bargaining, unless the collective bargaining agreement provides otherwise.
- Certain nonresident aliens who have no earned income from sources within the United States.
- Leased employees.
- Reclassified employees (a person the employer does not treat as a common law employee on its payroll records, such as someone paid as an independent contractor or an out-sourced worker).
- Temporary employees. However, if as a temporary employee, you complete one (1) year of service in any year of employment, you will no longer be part of this excluded class.
- Seasonal employees. However, if as a seasonal employee, you complete one (1) year of service in any year of employment, you will no longer be part of this excluded class.

Additional excluded employee provisions
As to elective deferrals and safe harbor matching contributions, exclude employees that are grandfathered as eligible to participate in the Retirement Plan for the Employees of Ben E. Keith Company and Its Affiliates.

How is my service determined for purposes of Plan eligibility?

- **By year of service**. You will be credited with one (1) year of service at the end of the twelve month period beginning on your date of hire if you have been credited with at least 1,000 hours of service during such period. If you have not been credited with 1,000 hours of service by the end of such period, you will have completed a year of service at the end of any following Plan year during which you were credited with 1,000 hours of service.
- **By hours of service, if hourly records are kept for you.** You will be credited with your actual hours of service for:
  - **a)** Each hour for which you are directly or indirectly compensated by the employer for the performance of duties during the Plan year.
  - **b)** Each hour for which you are directly or indirectly compensated by the employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan year) but credit will not exceed 501 hours of service for any single continuous period during which you perform no duties.
  - **c)** Each hour for back pay awarded or agreed to by the employer.

  You will not be credited for the same hours of service both under (a) or (b), as the case may be, and under (c).
- **By hours of service, if hourly records are not kept for you.** The Plan does not credit you with your actual hours of service. Instead, the Plan uses the weekly "equivalency" method. Under the equivalency method, you will be credited with the stated number of hours of service for the period from the following list provided you complete at least one hour of service during the specified period:
  - 10 hours of service for each day (daily method).
  - 45 hours of service for each week (weekly method).

- 95 hours of service for each semi-monthly payroll period (semi-monthly payroll period method).
- 190 hours of service for each month (monthly method).

How service is counted

You will have completed the required number of months if you are employed by the employer at any time after you complete that number of months.

- **Service with the employer.** In determining whether you satisfy the minimum service requirements to participate under the Plan, all service you perform for the employer will be counted.
- **Additional service with another employer provisions.** Any employee, who on October 1, 2016, was working for either Ben E. Keith Foods, Southeast Division or Kelley Manufacturing, a Division of Ben E. Keith Foods, shall receive credit for employment prior to such date with Kelley Manufacturing of Alabama, Inc. for purposes of determining eligibility and vesting.
- **Military service.** If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the employer. If you may be affected by this law, contact Empower Retirement for further details.

If you are a participant, terminate employment and are then rehired

If you are no longer a participant because of a termination of employment, and you are rehired, you will then be able to participate in the Plan on the date on which you are rehired if you are otherwise eligible to participate in the Plan.

Employee 401(k) contributions

Elective deferrals and how to contribute them to the Plan

As a participant in the BEK 401(k) Plan, you may elect to reduce your compensation by a specific percentage or dollar amount and have that amount contributed to the Plan as an elective deferral. There are two types of elective deferrals: pre-tax deferrals and Roth deferrals. For purposes of this SPD, "elective deferrals" generally means both pre-tax deferrals and Roth deferrals. Regardless of the type of deferral you make, the amount you defer is counted as compensation for purposes of Social Security taxes.

- **Pre-tax deferrals.** If you elect to make pre-tax deferrals, then your taxable income will be reduced because of the deferral contributions so you pay less in federal income taxes. Later, when the Plan distributes the deferrals and earnings, you will pay the taxes on those deferrals and the earnings. Therefore, with a pre-tax deferral, federal income taxes on the deferral contributions and on the earnings are only postponed. Eventually, you will have to pay taxes on these amounts.
- **Roth deferrals.** If you elect to make Roth deferrals, the deferrals are subject to federal income taxes in the year of deferral. However, the deferrals and, in certain cases, the earnings on the deferrals are not subject to federal income taxes when distributed to you. In order for the earnings to be tax free, you must meet certain conditions. See the *Tax consequences* section later in this chapter for more information.

401(k) deferral procedures

The amount you elect to defer to your BEK 401(k) will be deducted from your pay in accordance with a procedure established by the Plan Administrator. You may elect to defer a portion of your compensation payable on or after your entry date. Such election will become effective as soon as administratively feasible after it is received by the Plan Administrator. Your election will remain in effect until you modify or terminate it.

Deferral modifications. You may revoke or make modifications to your 401(k) salary deferral election in accordance with procedures that the employer provides. Contact Empower Retirement for additional information.

Deferral limit. As a participant, you may elect to defer up to 75% of your payroll period compensation.

Annual dollar limit. Your total deferrals in any taxable year may not exceed a dollar limit which is set by law. The limit for 2022 is $20,500. After 2022, the dollar limit may increase for cost-of-living adjustments.

Catch-up contributions. If you are at least age 50 or will attain age 50 before the end of a calendar year, then you may elect to defer additional amounts (called "catch-up contributions") to the plan for that year. The additional amounts may be deferred regardless of any other limitations on the amount that you may defer to the plan. The maximum "catch-up contribution" that you can make in 2022 is $6,500. After 2022, the maximum may increase for cost-of-living adjustments. Any "catch-up contributions" that you make will be taken into account in determining any employer matching contribution made to the Plan.

You should be aware that each separately stated annual dollar limit on the amount you may defer (the annual deferral limit and the "catch-up contribution" limit) is a separate aggregate limit that applies to all such similar elective deferral amounts and "catch-up contributions" you may make under this Plan and any other cash or deferred arrangements (including tax-sheltered 403(b) annuity contracts, simplified employee pensions or other 401(k) plans) in which you may be participating. Generally, if an annual dollar limit is exceeded, then the excess must be returned to you in order to avoid adverse tax consequences. For this reason, it is desirable to request in writing that any such excess elective deferral amounts be returned to you.

If you are in more than one plan, you must decide which plan or arrangement you would like to return the excess. If you decide that the excess should be distributed from this Plan, you must communicate this in writing to the Plan Administrator no later than the March 1st following the close of the calendar year in which such excess deferrals were made. However, if the entire dollar limit is exceeded in this Plan or any other plan the Employer maintains, then you will be deemed to have notified the Plan Administrator of the excess. The Plan Administrator will then return the excess deferral and any earnings to you by April 15th.

Automatic deferral. The BEK 401(k) includes an automatic deferral feature. Accordingly, Ben E. Keith will automatically withhold a portion of your compensation from your pay each payroll period and contribute that amount to the Plan as a pre-tax 401(k) deferral unless you make a contrary election.

The automatic deferral provisions apply to all participants, regardless of any prior salary reduction agreement, unless and until they. Make a contrary election after the automatic deferral effective date.

- You may complete a salary reduction agreement at any time to select an alternative deferral amount or to elect not to defer under the Plan in accordance with the deferral procedures of the Plan.
- The amount to be automatically withheld from your pay each payroll period will be equal to 4% of your compensation, and that amount will increase by 1% each Plan year until the amount withheld from your paycheck reaches 10% of your compensation unless the employer amends the Plan or you enter a salary reduction agreement.
- The increase in the amount automatically withheld from your pay will be effective on the first day of the Plan year, beginning with the first Plan year following the date deferrals were first automatically withheld from your pay.

Contact Empower Retirement if you have any questions concerning automatic 401(k) deferral provisions.

401(k) rollover contributions

At the discretion of the Plan Administrator, if you are an eligible employee, you may be permitted to deposit into the Plan distributions you have received from other plans and certain IRAs. Such a deposit is called a "rollover" and may result in tax savings to you. You may ask the Plan Administrator or Trustee of the other plan or IRA to directly transfer (a "direct rollover") to this Plan all or a portion of any amount that you are entitled to receive as a distribution from such plan. Alternatively, you may elect to deposit any amount eligible to be rolled over within 60 days of your receipt of the distribution. You should consult qualified counsel to determine if a rollover is in your best interest.

Your rollover will be accounted for in a "rollover account." You will always be 100% vested in your "rollover account" (see the *Vesting* section of this chapter). This means that you will always be entitled to all amounts in your rollover account. Rollover contributions will be affected by any investment gains or losses.

Withdrawal of rollover contributions

You may withdraw the amounts in your "rollover account" at any time. Review the *Distributions* section of this chapter for an explanation of how benefits (including your "rollover account") are paid from the Plan.

In-plan Roth rollover contributions

Effective July 1, 2018, if you are eligible for a distribution from an account, you may elect to roll over the distribution to a designated Roth contribution account in the Plan (referred to as an in-plan Roth rollover contribution). You may only roll over the distribution directly. However, loans may not be rolled over as an in-plan Roth rollover contribution.

Taxation and irrevocable elections

You do not pay taxes on the contributions or earnings of your pre-tax accounts (including accounts attributable to employer matching contributions and accounts attributable to employer nonelective contributions) until you receive an actual distribution. In other words, the taxes on the contributions and earnings in your pre-tax accounts are deferred until a distribution is made. Roth accounts, however, are the opposite. With a Roth account you pay current taxes on

the amounts contributed. When a distribution is made to you from the Roth account, you do not pay taxes on the amounts you had contributed. In addition, if you have a "qualified distribution" (explained below), you do not pay taxes on the earnings that are attributable to the contributions.

If you elect an in-plan Roth rollover contribution, then the contribution will be included in your income for the year. Once you make an election, it cannot be changed. It's important that you understand the tax effects of making the election and ensure you have adequate resources outside of the plan to pay the additional taxes. The in-plan Roth rollover contribution does not affect the timing of when a distribution may be made to you under the Plan; the contribution only changes the tax character of your account. You should consult with your tax advisor prior to making such a rollover.

Qualified distribution. As explained above, a distribution of the earnings on your Roth account will not be subject to tax if the distribution is a "qualified distribution." A "qualified distribution" is one that is made after you have attained age 59½ or is made on account of your death or disability. In addition, in order to be a "qualified distribution," the distribution cannot be made prior to the expiration of a 5-year participation period. The 5-year participation period is the 5-year period beginning on the calendar year in which you first make the Roth rollover and ending on the last day of the calendar year that is 5-years later. See the *Tax treatment of distributions* section of this chapter for more information.

The law restricts any in-service distributions from certain accounts which are maintained for you under the Plan before you reach age 59½. These accounts are the ones set up to receive your salary deferral contributions and other employer contributions which are used to satisfy special rules for 401(k) plans (such as safe harbor contributions). Contact Empower Retirement if you need more details.

In-plan 401(k) Roth transfers

Effective July 1, 2018, as a participant under the Plan, you may make an in-plan Roth transfer. An in-plan Roth transfer allows you to elect to change the tax treatment of all or some of the vested portion of your pre-tax accounts, as explained below. However, loans may not be rolled over as an in-plan Roth transfer.

Taxation and irrevocable election. You do not pay taxes on the contributions or earnings of your pre-tax accounts (including accounts attributable to employer matching contributions and accounts attributable to employer nonelective contributions) until you receive an actual distribution. In other words, the taxes on the contributions and earnings in your pre-tax accounts are deferred until a distribution is made. Roth accounts, however, are the opposite. With a Roth account you pay current taxes on the amounts contributed. When a distribution is made to you from the Roth account, you do not pay taxes on the amounts you had contributed. In addition, if you have a "qualified distribution" (explained below), you do not pay taxes on the earnings that are attributable to the contributions.

The in-plan Roth transfer allows you to transfer amounts from the vested portion of your pre-tax accounts to an in-plan Roth transfer account. If you elect to make such a transfer, then the amount transferred will be included in your income for the year. Once you make an election, it cannot be changed. It's important that you understand the tax effects of making the election and ensure you have adequate resources outside of the plan to pay the additional taxes. The in-plan Roth transfer does not affect the timing of when a distribution may be made to you under the Plan; the transfer only changes the tax character of your account. You should consult with your tax advisor prior to making a transfer election.

Qualified distribution

As explained previously, a distribution of the earnings on your Roth account will not be subject to tax if the distribution is a "qualified distribution." A "qualified distribution" is one that is made after you have attained age 59½ or is made on account of your death or disability. In addition, in order to be a "qualified distribution," the distribution cannot be made prior to the expiration of a 5-year participation period. The 5-year participation period is the 5-year period beginning on the calendar year in which you first make the Roth transfer and ending on the last day of the calendar year that is 5 years later. See the *Tax consequences* section later in this chapter for more information.

Employer 401(k) contributions

In addition to any deferrals you elect to make, the employer will make additional contributions to the Plan. This section describes employer contributions that will be made to the Plan and how your share of the contributions is determined.

Qualified safe harbor 401(k) Plan
This Plan is referred to as a "qualified automatic contribution arrangement 401(k) plan" also known as a QACA. Before the beginning of each Plan year, you will be provided with a comprehensive notice of your rights and obligations under the Plan. However, if you become eligible to participate in the Plan after the beginning of the Plan year, then the notice will be provided to you on or before the date you are eligible. A safe harbor QACA plan is a plan design where the employer commits to making certain contributions described below. This commitment to make contributions enables the employer to simplify the administration of the Plan by ensuring that nondiscrimination regulations are met, which is why it is called a "safe harbor" plan.

In order to maintain "QACA safe harbor" status, the employer will make a safe harbor matching contribution equal to 100% of your elective deferrals that do not exceed 4% of your compensation. This safe harbor matching contribution is subject to a vesting schedule shown later in this chapter.

For purposes of calculating this safe harbor matching contribution, your compensation and deferrals will be computed for each Plan year.

Allocating nonelective Profit Sharing contributions
Each year, Ben E. Keith Company may make a discretionary nonelective contribution to the Profit Sharing Plan. If you are employed on the last day of the Plan year, you will share regardless of the amount of service you complete during the Plan Year.

Waiver of allocation conditions
You will share in the nonelective contribution for the year you terminate employment regardless of the amount of service you complete during the Plan year if you terminate on or following your death, disability or attainment of normal retirement age.

Determining how Profit Sharing contributions are allocated
The nonelective contribution will be "allocated" or divided among participants eligible to share in the contribution for the Plan year.

Your share of the nonelective contribution is determined by the following fraction:

$$\text{Nonelective contribution} \times \frac{\text{Your compensation}}{\text{Total compensation of all participants eligible to share}}$$

For example: Suppose the nonelective contribution for the Plan year is $20,000. Employee A's compensation for the Plan year is $25,000. The total compensation of all participants eligible to share, including Employee A, is $250,000. Employee A's share will be:

$$\$20{,}000 \times \frac{\$25{,}000}{\$250{,}000} = \$2{,}000$$

Forfeitures

Definition of forfeitures. In order to reward employees who remain employed with the Company for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that the employer makes to the Plan. This means that you will not be entitled to ("vested" in) all of the contributions until you have been employed with the Employer for a specified period of time (see the *Vesting* section later in this chapter).

If a participant terminates employment before being fully vested, then the non-vested portion of the terminated participant's account balance remains in the Plan and is called a forfeiture. Forfeitures may be used by the Plan for several purposes.

For instance, forfeitures may be used to pay Plan expenses, used to reduce any nonelective contribution or used to reduce any matching contribution.

Compensation and account balances

Compensation is defined as your total compensation that is subject to income tax and paid to you by the employer. If you are a self-employed individual, your compensation will be equal to your earned income. The following describes the adjustments to compensation that apply for the contributions noted previously.

Adjustments to compensation

The following adjustments to compensation will be made:

- Compensation paid after you terminate is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2½ months after you terminate employment, or if later, the last day of the Plan year in which you terminate employment:
  - Compensation paid for services performed during your regular working hours, or for services outside your regular working hours (such as overtime or shift differential), or other similar payments that would have been made to you had you continued employment.
  - Compensation paid for unused accrued bona fide sick, vacation or other leave, if such amounts would have been included in compensation if paid prior to your termination of employment and you would have been able to use the leave if employment had continued.

Elective deferrals

In addition to adjustments to compensation under the previously mentioned *All contributions* section, the following adjustments to compensation will be made for purposes of elective deferrals:

- Elective deferrals to this Plan and to any other plan or arrangement (such as a cafeteria plan) will be included.
- Reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits will be excluded.
- Compensation paid while not a participant in this component of the Plan will be excluded.
- Compensation paid by a related employer that is not a participating employer will be excluded.

Safe harbor matching contributions

In addition to adjustments to compensation under *All contributions* above, the following adjustments to compensation will be made for purposes of safe harbor matching contributions:

- Elective deferrals to this Plan and to any other plan or arrangement (such as a cafeteria plan) will be included.
- Reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits will be excluded.
- Compensation paid while not a participant in this component of the Plan will be excluded.
- Compensation paid by a related employer that is not a participating employer will be excluded.

Nonelective contributions

In addition to adjustments to compensation under *All contributions* above, the following adjustments to compensation will be made for purposes of nonelective contributions:

- Elective deferrals to this Plan and to any other plan or arrangement (such as a cafeteria plan) will be included.
- Reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits will be excluded.
- Compensation paid by a related employer that is not a participating employer will be excluded.

See *Additional compensation adjustment provisions* in the following section for special provisions that may apply to compensation adjustments.

Additional compensation adjustment provisions

As to nonelective Profit Sharing contributions for a participant's initial Plan year of participation, exclude an amount equal to the participant's compensation for such Plan year, multiplied by the fraction of the Plan year elapsed before the participant's entry date for nonelective contributions.

Limits on the amount of compensation

The Plan, by law, cannot recognize annual compensation in excess of a certain dollar limit. The limit for the Plan year beginning in 2022 is $305,000. After 2022, the dollar limit may increase for cost-of-living adjustments.

Limits on how much can be contributed to your account each year
Generally, the law imposes a maximum limit on the amount of contributions (excluding catch-up contributions) that may be made to your account and any other amounts allocated to any of your accounts during the Plan year, excluding earnings. Beginning in 2022, this total cannot exceed the lesser of $61,000 or 100% of your annual compensation (as limited under the previous section). After 2022, the dollar limit may increase for cost-of-living adjustments.

How money is invested
The Trustee of the Plan has been designated to hold the assets of the Plan for the benefit of Plan participants and their beneficiaries in accordance with the terms of this Plan. The trust fund established by the Plan's Trustee will be the funding medium used for the accumulation of assets from which Plan benefits will be distributed.

You will be able to direct the investment of your entire interest in the Plan. Empower Retirement will provide you with information on the investment choices available to you, the procedures for making investment elections, the frequency with which you can change your investment choices and other important information. You need to follow the procedures for making investment elections and you should carefully review the information provided to you before you give investment directions. If you do not direct the investment of your applicable Plan accounts, then your accounts will be invested in accordance with the default investment alternatives established under the Plan. These default investments will be made in accordance with specific rules under which the fiduciaries of the Plan, including the employer, the Trustee and Empower Retirement, will be relieved of any legal liability for any losses resulting from the default investments. Empower Retirement has or will provide you with a separate notice which details these default investments and your right to switch out of the default investment if you so desire.

The Plan is intended to comply with Section 404(c) of ERISA (the Employee Retirement Income Security Act). If the Plan complies with this Section, then the fiduciaries of the Plan, including the employer, the Trustee and the Plan Administrator, will be relieved of any legal liability for any losses which are the direct and necessary result of the investment directions that you give. Procedures must be followed in giving investment directions. If you fail to do so, then your investment directions need not be followed. If you do not direct the investment of your applicable Plan accounts, your accounts will be invested in accordance with the default investment alternatives established under the Plan.

Earnings or losses
When you direct investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your participant-directed account does not share in the investment performance of other participants who have directed their own investments. You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well as losses can occur and the Company, Empower Retirement, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

Periodically, you will receive a benefit statement that provides information on your account balance and your investment returns. It is your responsibility to notify Empower Retirement of any errors you see on any statements within 30 days after the statement is provided or made available to you.

Plan expenses that are deducted from your account balance
The Plan will pay some or all Plan related expenses except for a limited category of expenses, known as "settlor expenses," which the law requires the employer to pay. Generally, settlor expenses relate to the design, establishment or termination of the Plan. Contact Empower Retirement for more details. The expenses charged to the Plan may be charged pro rata to each participant in relation to the size of each participant's account balance or may be charged equally to each participant. In addition, some types of expenses may be charged only to some participants based upon their use of a Plan feature or receipt of a plan distribution. Finally, the Plan may charge expenses in a different manner as to participants who have terminated employment with the employer versus those participants who remain employed with the employer.

Vesting in Profit Sharing contributions
In order to reward employees who remain employed with the employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that the employer makes to the Plan. This means that you will

not be entitled to ("vested in") all of the contributions until you have been employed with the employer for a specified period of time.

You are always 100% vested (which means that you are entitled to all of the amounts) in your accounts attributable to the following contributions:

- Elective deferrals including Roth 401(k) deferrals and catch-up contributions.
- Rollover contributions.

Your "vested percentage" for certain employer contributions is based on vesting periods of service. This means at the time you stop working, your account balance attributable to contributions subject to a vesting schedule is multiplied by your vested percentage. The result, when added to the amounts that are always 100% vested as shown above, is your vested interest in the Plan, which is what you will actually receive from the Plan.

Nonelective Profit Sharing contributions

Your "vested percentage" in your account attributable to nonelective Profit Sharing contributions is determined under the following schedule. You will always, however, be 100% vested in your nonelective Profit Sharing contributions if you are employed on or after your normal retirement age or if you terminate employment on account of your death, or if you terminate employment as a result of becoming disabled.

Vesting schedule – nonelective Profit Sharing contributions

Years of service	Percentage vested
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6	100%

Qualified safe harbor contributions

Your "vested percentage" in your account attributable to qualified safe harbor contributions is determined under the following schedule. You will always, however, be 100% vested in your qualified safe harbor contributions if you are employed on or after your Normal Retirement Age or if you terminate employment on account of your death, or if you terminate employment as a result of becoming disabled.

Vesting schedule – qualified safe harbor contributions

Years of service	Percentage vested
Less than 2	0%
2	100%

How service is determined for vesting purposes

You will be credited with a period of service for each twelve-month period from your date of hire until the date your employment terminates. The Plan Administrator will track your service and will credit you with a period of service in accordance with the terms of the Plan. If you have any questions regarding your vesting service, you should contact Empower Retirement.

Services that count for vesting purposes

- **Service with the employer.** In calculating your vested percentage, all service you perform for the employer will generally be counted.
- **Additional service with another employer provisions.** Any employee, who on October 1, 2016, was working for either Ben E. Keith Foods-Southeast Division or Kelley Manufacturing – A Division of Ben E. Keith Foods, shall receive credit for employment prior to such date with Kelley Manufacturing of Alabama, Inc. for purposes of determining eligibility and vesting.

- **Military service.** If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the employer. If you may be affected by this law, ask the Plan Administrator for further details.

What happens to your non-vested account balance if you are rehired?
If you have no vested interest in the Plan when you leave, your account balance will be forfeited. However, if you are rehired before incurring five consecutive breaks in service, your account balance as of the date of your termination of employment will be restored, unadjusted for any gains or losses.

If you are partially vested in your account balance when you leave, the non-vested portion of your account balance will be forfeited on the earlier of the date:
a) Of the distribution of your vested account balance, or
b) When you incur five consecutive breaks in service.

If you received a distribution of your vested account balance and are rehired, you may have the right to repay this distribution. If you repay the entire amount of the distribution, the employer will restore your account balance with your forfeited amount. You must repay this distribution within five years from your date of rehire, or, if earlier, before you incur five consecutive breaks in service. If you were 100% vested when you left, you do not have the opportunity to repay your distribution.

If the Plan becomes a "top-heavy plan"
A retirement plan that primarily benefits key employees is called a "top-heavy plan." Key employees are certain owners or officers of the employer. A plan is generally a "top-heavy plan" when more than 60% of the plan assets are attributable to key employees. Each year, the Plan Administrator is responsible for determining whether the Plan is a "top-heavy plan."

If the Plan becomes top-heavy in any Plan year, then non-key employees may be entitled to certain "top-heavy minimum benefits," and other special rules will apply. These top-heavy rules include the following:
- The employer may be required to make a contribution on your behalf in order to provide you with at least "top-heavy minimum benefits."
- If you are a participant in more than one Plan, you may not be entitled to "top-heavy minimum benefits" under both Plans.

Distributions prior to termination of employment

Withdrawing money from your account while working
You may be entitled to receive an in-service distribution. However, this distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive at retirement. This distribution is made at your election subject to possible administrative limitations on the frequency and actual timing of such distributions. You may withdraw amounts from your rollover contributions accounts at any time.

Conditions and limitations
Generally, you may receive a distribution from certain accounts prior to termination of employment provided you satisfy any of the following conditions:
- You have attained age 59½. Satisfying this condition allows you to receive distributions from all contribution accounts.
- You have incurred a financial hardship as described in the following:
  - **Qualified reservist distributions.** If you: (i) are a reservist or National Guardsman; (ii) were/are called to active duty after September 11, 2001; and (iii) were/are called to duty for at least 180 days or for an indefinite period, you may take a distribution of your elective deferrals under the Plan while you are on active duty, regardless of your age. The 10% premature distribution penalty tax, normally applicable to Plan distributions made before you reach age 59½, will not apply to the distribution. You also may repay the distribution to an IRA, without limiting amounts you otherwise could contribute to the IRA, provided you make the repayment within 2 years following your completion of active duty.
  - **Distributions for deemed severance of employment.** If you are on active duty for more than 30 days, then the Plan generally treats you as having severed employment for purposes of receiving a distribution from all contribution accounts. This means that you may request a distribution from all contribution accounts from the

Plan. If you request a distribution on account of this deemed severance of employment and all or part of the distribution is taken from elective deferrals, then you are not permitted to make any contributions to the Plan for six (6) months after the date of the distribution.

Withdrawing money from your account in the event of financial hardship
You may withdraw money on account of financial hardship if you satisfy certain conditions. This hardship distribution is not in addition to your other benefits and will therefore reduce the value of the benefits you will receive upon termination of employment or other event entitling you to distribution of your account balance.

Qualifying expenses
A hardship distribution may be made to satisfy certain immediate and heavy financial needs that you have. A hardship distribution may only be made for payment of the following:

- Expenses for medical care (described in Section 213(d) of the Internal Revenue Code) for you, your spouse or your dependents. This also includes medical expenses for the death beneficiary of your Plan account.
- Costs directly related to the purchase of your principal residence (excluding mortgage payments).
- Tuition, related educational fees, and room and board expenses for the next twelve (12) months of post-secondary education for you, your spouse, your children or your dependents. This also includes such education expenses for the death beneficiary of your Plan account.
- Amounts necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence.
- Payments for burial or funeral expenses for your deceased parent, spouse, children or dependents. This also includes burial or funeral expenses for the death beneficiary of your Plan account.
- Expenses for the repair of damage to your principal residence (that would qualify for the casualty loss deduction under Internal Revenue Code Section 165) without regard to the limit on casualty losses that are deductible for income tax purposes under IRC 165(h).
- Expenses for disasters arising from federally declared disasters, such as your expenses and losses (including loss of income) attributable to that disaster, provided your principal residence or place of employment was in an area FEMA designates as qualifying for individual assistance.

For this purpose, your beneficiary is the person you designate under the Plan (or the Plan otherwise designates in the absence of your designation) to receive your death benefit and who is not necessarily your spouse or dependent.

Conditions
If you have any of the above expenses, a hardship distribution can only be made if you certify and agree that all of the following conditions are satisfied:

a) The distribution is not in excess of the amount of your immediate and heavy financial need. The amount of your immediate and heavy financial need may include any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution.
b) You have obtained all distributions, other than hardship distributions, currently available under all plans that the employer maintains.
c) You certify (via a form for that purpose) that you have insufficient cash or other liquid assets reasonably available to satisfy the need.

Account restrictions
You may request a hardship distribution only from the vested portion of the following accounts:

- Pre-tax 401(k) deferral accounts plus earnings.
- Roth 401(k) deferral accounts plus earnings.
- Account(s) attributable to employer nonelective contributions.

Distributions upon termination of employment

When you can take money out of the Plan
You may receive a distribution of the vested portion of some or all of your accounts in the Plan when you terminate employment with the employer. The rules regarding the payment of death benefits to your beneficiary are described in the *Distributions upon death* section later in this chapter.

As to the possibility of receiving a distribution while you are still employed with the employer, see the *Distributions prior to termination of employment* section later in this chapter.

Military service
If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the employer. There may also be benefits for employees who die or become disabled while on active duty. Employees who receive wage continuation payments while in the military may benefit from various changes in the law. If you think you may be affected by these rules, ask Empower Retirement for further details.

Termination and distribution before normal retirement age (or age 62 if later)
If your vested account balance exceeds $5,000, your consent is required to distribute your account before you reach normal retirement age (or age 62 if later). You may elect to have your vested account balance distributed to you as soon as administratively feasible following your termination of employment. (See *In what method and form will my benefits be paid to me?* for an explanation of the method of payment.)

If you terminate employment with a vested account balance exceeding $5,000, you may elect to postpone your distribution until your "required beginning date" described below.

If your vested account balance does not exceed $5,000, a distribution of your vested account balance will be made to you, regardless of whether you consent to receive it, as soon as administratively feasible following your termination of employment. (See *In what method and form will my benefits be paid to me?* for an explanation of the method of payment.)

Amounts in your rollover account will not be considered as part of your benefit in determining whether the $5,000 threshold for timing of payments described previously has been exceeded as well as for determining if the value of your vested account balance exceeds the $5,000 threshold used to determine whether you must consent to a distribution.

Automatic rollover of certain account balances
If your vested account balance does not exceed $5,000, the Plan will distribute your account without your consent. If the amount of the distribution exceeds $0.01 (including any rollover contribution) and you do not elect to either receive or roll over the distribution, your distribution will be directly rolled over to an IRA. See the *Tax treatment of distributions* section later in this chapter for more information.

Distribution on or after normal retirement age (or age 62 if later)
If you terminate employment with the employer and will receive distribution on or after the later of age 62 or normal retirement age, the Plan will distribute your account without your consent. The distribution will occur as soon as administratively feasible at the same time described above for other pre-62/normal retirement age distributions not requiring your consent, but in any event, distribution will be made no later than 60 days after the end of the Plan year in which you terminate employment. Notwithstanding the foregoing, if your vested account balance exceeds $5,000 (including rollover contributions), you may elect to postpone your distribution until your "required beginning date" described below.

Normal retirement age and the significance of reaching normal retirement age
You will attain your normal retirement age when you reach age 65.

You will become 100% vested in all of your accounts under the Plan (assuming you are not already fully vested) if you are employed on or after your normal retirement age.

Terminating employment due to disability
Under the Plan, disability is defined by the employer’s disability insurance program. Contact Lincoln Financial Group, Ben E. Keith disability carrier, for additional information about disability.

Payment of benefits
If you terminate employment because you become disabled, you will become 100% vested in all of your accounts under the Plan and the Plan will distribute your account balance in the same manner as for any other non-death related termination.

How balance is paid

Termination and distribution before normal retirement age (or age 62 if later)
If you terminate employment and will receive a distribution before the later of age 62 or normal retirement age and your vested account balance does not exceed $5,000, then your vested account balance may only be distributed to you in a single lump-sum payment in cash. If you are less than 100% vested in your account balance and have not incurred a forfeiture break in service, then your vested account balance may only be distributed to you in a single lump-sum payment in cash. A forfeiture break in service occurs after five consecutive one-year breaks in service. A break in service is a Plan year in which you are not credited with at least 501 hours of service.

If you terminate employment and will receive a distribution before the later of age 62 and normal retirement age and your vested account balance exceeds $5,000, you may elect to receive a distribution of your vested account balance in:

- A single lump-sum payment in cash.
- Installments over a period of not more than your assumed life expectancy (or the assumed life expectancies of you and your beneficiary).
- You may request a partial distribution of some or all of your Plan accounts, at any time following your termination of employment, subject to any reasonable limits regarding timing and amounts as the Plan Administrator may impose.

In determining whether your vested account balance exceeds the $5,000 dollar threshold, "rollovers" (and any earnings allocable to "rollover" contributions) will not be taken into account.

Distribution on or after normal retirement age (or age 62 if later)
If you terminate employment and will receive distribution on or following the attainment of the later of age 62 or normal retirement age, and your vested account balance (including rollovers) does not exceed $5,000, you will receive distribution in the form of a single lump- sum payment in cash. If your balance exceeds $5,000, you may elect to receive distribution as described above relating to termination before the later of age 62 and normal retirement age. In determining whether your vested account balance exceeds the $5,000 dollar threshold, "rollovers" (and any earnings allocable to "rollover" contributions) will be taken into account.

Required beginning date
As described above, you may delay the distribution of your vested account balance. However, if you elect to delay the distribution of your vested account balance, there are rules that require that certain minimum distributions be made from the Plan. If you are a 5% owner, distributions are required to begin no later than the April 1st following the end of the year in which you reach age 70½. If you are not a 5% owner, distributions are required to begin no later than the April 1st following the later of the end of the year in which you reach age 70½ or terminate employment. Contact Empower Retirement for additional information.

Distributions upon death

If you die while still employed by the Company, then 100% of your account balance will be used to provide your beneficiary with a death benefit.

Who will receive your death benefit?
You may designate a beneficiary of your Plan account on a form provided to you for this purpose by Empower Retirement. If you do not designate a beneficiary, your account will be distributed as described in the following *If no beneficiary is designated* section. If you are married, your spouse has certain rights to the death benefit. You should immediately report any change in your marital status to Empower Retirement.

If you are a married participant
If you are married at the time of your death, your spouse will be the beneficiary of the entire death benefit unless you designate in writing a different beneficiary. **If you wish to designate a beneficiary other than your spouse, your spouse must irrevocably consent to waive any right to the death benefit. Your spouse's consent must be in writing, be witnessed by a notary or a plan representative and acknowledge the specific non-spouse beneficiary.**

Changes to beneficiary designation
If, with spousal consent as required, you have designated someone other than your spouse as beneficiary and now wish to change your designation, contact Empower Retirement for details. In addition, you may elect a beneficiary other than your spouse without your spouse's consent if your spouse cannot be located.

Divorce
A divorce decree automatically revokes your designation of your spouse or former spouse as your beneficiary under the Plan unless a Qualified Domestic Relations Order provides otherwise. You should complete a form to make a new beneficiary designation if a divorce decree is issued. Contact Empower Retirement for details if you think you may become affected by this provision.

Unmarried participant
If you are not married, you may designate a beneficiary of your choosing. Contact Empower Retirement to designate a beneficiary.

If no beneficiary is designated
At the time of your death, if you have not designated a beneficiary or the individual named as your beneficiary is not alive, then the death benefit will be paid in the following order of priority: first to the participant's spouse, then to the participant's estate.

How death benefits will be paid to your beneficiary
The form of payment of the death benefit will be in cash. If the death benefit payable to a beneficiary does not exceed $5,000, then the benefit may only be paid as a lump sum. If the death benefit exceeds $5,000, your beneficiary may elect to have the death benefit paid in:

- A single lump-sum payment in cash.
- Annual installments at least equal to the required minimum distribution amount.
- Partial distributions. Your beneficiary may request a distribution of some or all of the death benefit, at any time following your death, subject to any reasonable limits Empower Retirement may impose. Each such distribution must be at least equal to the required minimum distribution amount.

Timing of distribution
Payment of the death benefit must begin by the end of the calendar year which follows the year of your death if your designated beneficiary is a person, unless you die before your required beginning date and your designated beneficiary elects to have the entire death benefit paid by the end of the fifth year following the year of your death as indicated below. If your designated beneficiary is not a person, then your entire death benefit must generally be paid within five years after your death.

When the last payment will be made to your beneficiary (required minimum distributions)
The law generally restricts the ability of a retirement plan to be used as a method of deferring taxation for an unlimited period beyond the participant's life. Thus, there are rules that are designed to ensure that death benefits are distributable to beneficiaries within certain time periods. The application of these rules depends upon whether you die before or after your "required beginning date" as described previously in the *Required beginning date* section.

Death before required beginning date
Regardless of the method of distribution a beneficiary might otherwise be able to elect, if your designated beneficiary is a person (other than your estate or certain trusts), then minimum distributions of your death benefit must begin no later than the end of the calendar year which follows the year of your death and must be paid over a period not extending beyond your beneficiary's life expectancy. However, instead of a life expectancy based distribution, your designated beneficiary may elect to have the entire death benefit paid by the end of the fifth year following the year of your death. Generally, if your beneficiary is not a person, then your entire death benefit must be paid within five years after your death.

If your spouse is the sole beneficiary, your spouse may delay the start of payments until the year in which you would have attained age 70½.

Death after required beginning date
If you die on or after your required beginning date, regardless of the method of distribution a beneficiary might otherwise be able to elect, payment must be made over a period which does not exceed the greater of the beneficiary's life expectancy or your remaining life expectancy (determined in accordance with applicable life

expectancy tables and without regard to your actual death). If your beneficiary is not a person, your entire death benefit must be paid over a period not exceeding your remaining life expectancy (determined in accordance with applicable life expectancy tables and without regard to your actual death).

If you terminate employment, commence payments and then die before receiving all of your benefits
Your beneficiary will be entitled to your remaining vested interest in the Plan at the time of your death. Contact Empower Retirement for more information regarding the timing and method of payments that apply to your beneficiary. The provision in the Plan providing for full vesting of your benefit upon death does not apply if you die after terminating employment.

Tax treatment of distributions

Tax consequences when you receive a distribution from the Plan
Generally, you must include any Plan distribution in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution. Certain distributions made to you when you are under age 59½ could be subject to an additional 10% tax.

You will not be taxed on distributions of your Roth 401(k) deferrals. In addition, a distribution of the earnings on the Roth 401(k) deferrals will not be subject to tax if the distribution is a "qualified distribution." A "qualified distribution" is one that is made after you have attained age 59½ or is made on account of your death or disability. In addition, in order to be a "qualified distribution," the distribution cannot be made prior to the expiration of a 5-year participation period. The 5-year participation period is the 5-year period beginning on the calendar year in which you first make a Roth 401(k) deferral to our Plan (or to another 401(k) plan or 403(b) plan if such amount was rolled over into this Plan) and ending on the last day of the calendar year that is 5 years later.

Qualified reservist distributions
If you: (i) are a reservist or National Guardsman; (ii) were/are called to active duty after September 11, 2001; and (iii) were/are called to duty for at least 180 days or for an indefinite period, you may take a distribution of your elective deferrals under the Plan while you are on active duty, regardless of your age. The 10% premature distribution penalty tax, normally applicable to Plan distributions made before you reach age 59½, will not apply to the distribution. You also may repay the distribution to an IRA, without limiting amounts you otherwise could contribute to the IRA, provided you make the repayment within 2 years following your completion of active duty.

Electing a rollover to reduce or defer tax on your distribution
You may reduce, or defer entirely, the tax due on your distribution through use of one of the following methods:

1. **60-day rollover.** You may roll over all or a portion of the distribution to an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the rollover. This will result in no tax being due until you begin withdrawing funds from the IRA or other qualified employer plan. The rollover of the distribution, however, MUST be made within strict time frames (normally, within 60 days after you receive your distribution). Under certain circumstances, all or a portion of a distribution (such as a hardship distribution) may not qualify for this rollover treatment. In addition, most distributions will be subject to mandatory federal income tax withholding at a rate of 20%. This will reduce the amount you actually receive. For this reason, if you wish to roll over all or a portion of your distribution amount, then the direct rollover option described in paragraph (b) below would be the better choice.
2. **Direct rollover.** For most distributions, you may request that a direct transfer (sometimes referred to as a direct rollover) of all or a portion of a distribution be made to either an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the transfer (See *In-plan Roth rollover contributions* for special rules on in-plan Roth rollovers). A direct transfer will generally result in no tax being due (unless you roll pre-tax accounts directly to a Roth IRA) until you withdraw funds from the IRA or other employer plan. Like the rollover, under certain circumstances all or a portion of the amount to be distributed may not qualify for this direct transfer. If you elect to actually receive the distribution rather than request a direct transfer, then in most cases 20% of the distribution amount will be withheld for federal income tax purposes.

Automatic IRA rollover of certain account balances
If a mandatory distribution is being made to you before the later of age 62 or normal retirement age and your vested account balance does not exceed $5,000 (disregarding any rollover contribution), the Plan will distribute your vested portion in a single lump-sum payment in cash. However, you may elect whether to receive the distribution or to roll over the distribution to another retirement plan such as an individual retirement account ("IRA"). At the time of your

termination of employment, the Plan Administrator will provide you with further information regarding your distribution rights. If the amount of the distribution exceeds $0.01 (including any rollover contribution) and you do not elect either to receive or to roll over the distribution, the Plan automatically will roll over the distribution to an IRA. The IRA provider will invest the rollover funds in a type of investment designed to preserve principal and to provide a reasonable rate of return and liquidity (e.g., an interest-bearing account, a certificate of deposit or a money market fund). The IRA provider will charge your account for any expenses associated with the establishment and maintenance of the IRA and with the IRA investments. In addition, your beneficiary designation under the Plan, if any, will not apply to the rollover IRA. The IRA's terms will control in establishing a designated beneficiary under the IRA. You may transfer the IRA funds to any other IRA you choose. Contact Empower Retirement at the address and telephone number indicated in this SPD for further information regarding the Plan's automatic rollover provisions, the IRA provider and the fees and charges associated with the IRA.

Important tax notice. Whenever you receive a distribution that is an eligible rollover distribution, Empower Retirement will provide you with a more detailed explanation of these options. However, the rules which determine whether you qualify for favorable tax treatment are very complex. Consult with qualified tax counsel before making a choice.

Loans

Borrowing money from the Plan
Loans are permitted in accordance with the Plan *Loan Policy*. If you wish to receive a copy of the *Loan Policy*, please contact Empower Retirement.

Protected benefits and claims procedures

As a general rule, your interest in your account, including your "vested interest," may not be alienated. This means that your interest may not be sold, used as collateral for a loan (other than for a Plan loan), given away or otherwise transferred (except at death to your beneficiary). In addition, your creditors (other than the IRS) may not attach, garnish or otherwise interfere with your benefits under the Plan.

Exceptions
There are three exceptions to this general rule. Empower Retirement must honor a qualified domestic relations order (QDRO). A QDRO is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, children or other dependents. If a QDRO is received by the Plan Administrator, all or a portion of your benefits may be used to satisfy that obligation. The Plan Administrator will determine the validity of any domestic relations order received. You and your beneficiaries can obtain from the Plan Administrator, without charge, a copy of the procedure used by Empower Retirement to determine whether a qualified domestic relations order is valid.

The second exception applies if you are involved with the Plan's operation. If you are found liable for any action that adversely affects the Plan, Empower Retirement can offset your benefits by the amount that you are ordered or required by a court to pay the Plan. All or a portion of your benefits may be used to satisfy any such obligation to the Plan.

The last exception applies to federal tax levies and judgments. The Federal Government is able to use your interest in the Plan to enforce a federal tax levy and to collect a judgment resulting from an unpaid tax assessment.

Amending the Plan
Ben E. Keith Company has the right to amend the Plan at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your account.

If the Plan is discontinued or terminated
Although the Company intends to maintain the Plan indefinitely, Ben E. Keith reserves the right to terminate the Plan at any time. Upon termination, no further contributions will be made to the Plan and all amounts credited to your accounts will become 100% vested. The distribution of your accounts will be done in a manner permitted by the Plan as soon as practicable. You will be notified if the Plan is terminated.

Submitting a claim

You may file a claim for benefits by submitting a written request for benefits to Empower Retirement. You should also contact them to see if there is an applicable distribution form that must be used. If no specific form is required or available, then your written request for a distribution will be considered a claim for benefits. In the case of a claim for disability benefits, if disability is determined by Empower Retirement (rather than by a third party such as the Social Security Administration), then you must also include with your claim sufficient evidence to enable Empower Retirement to make a determination on whether you are disabled.

Decisions on the claim will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days. If Empower Retirement determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

For purposes of the claims procedures described in the following section, "you" refers to you, your authorized representative, or anyone else entitled to benefits under the Plan (such as a beneficiary). A document, record, or other information will be considered relevant to a claim if it:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The Plan may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described below. If applicable, the Plan will not assert that you failed to exhaust administrative remedies for failure to use the voluntary procedures, any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending; and the voluntary process is available only after exhaustion of the appeals process described in this section. If mandatory arbitration is offered by the Plan, the arbitration must be conducted instead of the appeal process described in this section, and you are not precluded from challenging the decision under ERISA §501(a) or other applicable law.

If benefits are denied

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, Empower Retirement will provide you with a written or electronic notification of the Plan's adverse determination. This written or electronic notification must be provided to you within a reasonable period of time, but not later than 90 days (except as provided below for disability claims) after the receipt of your claim by Empower Retirement, unless they determine that special circumstances require an extension of time for processing your claim. If Empower Retirement determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

In the case of a claim for disability benefits, if disability is determined by Empower Retirement (rather than a third party such as the Social Security Administration), then instead of the above, the initial claim must be resolved within 45 days of receipt by the Plan. A Plan may, however, extend this decision-making period for an additional 30 days for reasons beyond the control of the Plan. The Plan will notify you of the extension prior to the end of the 45-day period. If, after extending the time period for a first period of 30 days, Empower Retirement determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 30-day period. Appropriate notice will be provided to you before the end of the first 45 days and again before the end of each succeeding 30-day period. This notice will explain the circumstances requiring the extension and the date Empower Retirement expects to render a decision. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent

a decision, and the additional information needed to resolve the issues. You will have 45 days from the date of receipt of the Plan Administrator's notice to provide the information required.

If Empower Retirement determines that all or part of the claim should be denied (an "adverse benefit determination"), it will provide a notice of its decision in written or electronic form explaining your appeal rights. An "adverse benefit determination" also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

a) The specific reason or reasons for the adverse determination.

b) Reference to the specific Plan provisions on which the determination was based.

c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

d) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

e) In the case of a claim for disability benefits, if disability is determined by Empower Retirement (rather than a third party such as the Social Security Administration, then the following additional information will be provided:

i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
- The views you presented to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
- A disability determination made by the Social Security Administration and presented by you to the Plan.

ii. Either the internal rules, guidelines, protocols, or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols, or other criteria do not exist.

iii. If the adverse benefit determination is based on a medical necessity or experimental treatment and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances. If this is not practical, a statement will be included that such explanation will be provided to you free of charge, upon request.

iv. 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.

If your claim has been denied, and you want to submit your claim for review, you must follow the claims review procedure.

Claims review procedure

Upon the denial of your claim for benefits, you may file your claim for review, in writing, with Empower Retirement.

a) You must file the claim for review no later than 60 days (except as provided below for disability claims) after you have received written notification of the denial of your claim for benefits.

If your claim is for disability benefits and disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration), then instead of the above, you must file the claim for review not later than 180 days following receipt of notification of an adverse benefit determination. In the case of an adverse benefit determination regarding a rescission of coverage, you must request a review within 90 days of the notice.

b) You may submit written comments, documents, records, and other information relating to your claim for benefits.

c) You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

d) Your claim for review must be given a full and fair review. This review will take into account all comments, documents, records, and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition to the claims review procedure above, if your claim is for disability benefits and disability is determined by Empower Retirement (rather than a third party such as the Social Security Administration), then:

a) Your claim will be reviewed without deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

b) If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

c) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

d) If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to you, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow you time to respond.

e) Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, Empower Retirement must provide you with a copy of the rationale at no cost to you. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow you time to respond.

Empower Retirement will provide you with written or electronic notification of the Plan's benefit determination on review. They must provide you with notification of this denial within 60 days (45 days with respect to claims relating to the determination of disability benefits) after the Plan Administrator's receipt of your written claim for review, unless the Plan Administrator determines that special circumstances require an extension of time for processing your claim. In such a case, you will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, Empower Retirement must notify you of the determination on review no later than 120 days (or 90 days with respect to claims relating to the determination of disability benefits).

The Plan Administrator will provide written or electronic notification to you in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

a) The specific reason or reasons for the adverse determination.

b) Reference to the specific Plan provisions on which the benefit determination was based.

c) 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 your claim for benefits.

d) In the case of a claim for disability benefits, if disability is determined by the Plan Administrator (rather than a third party such as the Social Security Administration):

- **i.** Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.
- **ii.** If the adverse benefit determination is based on a medical necessity or experimental treatment and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances. If this is not practical, a statement will be included that such explanation will be provided to you free of charge, upon request.
- **iii.** A statement of your right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to your right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

  If the Plan offers voluntary appeal procedures, a description of those procedures and your right to obtain sufficient information about those procedures upon request to enable you to make an informed decision about whether to submit to such voluntary appeal. These procedures will include a description of your right to representation, the process for selecting the decision maker and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on you as part of the voluntary appeal.

A decision whether to use the voluntary appeal process will have no effect on your rights to any other Plan benefits.

iv. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the Plan of health care professionals treating you and vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
- A disability determination made by the Social Security Administration and presented by you to the Plan.

If you have a claim for benefits which is denied, then you may file suit in a state or federal court. However, in order to do so, you must file the suit no later than 180 days after the date of the Plan Administrator's final determination denying your claim.

Your rights as a Plan participant
As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Review the **Plan administration and ERISA rights** chapter for more information on your rights.

General Plan information

Plan name
The full name of the Plan is Ben E. Keith Company Retirement Savings Plan.

Plan number
The Employer has assigned Plan Number 002 to your Plan.

Plan effective dates
This Plan was originally effective on July 1, 1942. The amended and restated provisions of the Plan become effective on February 2, 2022.

Other Plan information
Valuations of the Plan assets are made annually on the last day of the Plan Year. The Plan Administrator also may require more frequent valuations.

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan year. The Plan year ends on June 30. The Plan will be governed by the laws of the state of the employer's principal place of business to the extent not governed by federal law.

Benefits provided by the Plan are NOT insured by the Pension Benefit Guaranty Corporation (PBGC) under Title IV of the Employee Retirement Income Security Act of 1974 because the insurance provisions under ERISA are not applicable to this type of Plan.

Service of legal process may be made upon the employer. Service of legal process may also be made upon the Trustee or Plan Administrator.

Plan Trustee information and Plan funding medium

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund and must hold and invest Plan assets (unless the investment of assets is subject to participant or other direction) in a prudent manner and in the best interest of you and your beneficiaries. The trust fund established by the Plan's Trustee(s) will be the funding medium used for the accumulation of assets from which benefits will be distributed. While all the Plan assets are held in a trust fund, the Plan Administrator separately accounts for each participant's interest in the Plan. If there is more than one Trustee, they will collectively be referred to as Trustee throughout **The BEK Retirement Savings Plan** chapter.

The Plan's Trustee is:

Great-West Trust Company, LLC
8515 East Orchard Road
Greenwood Village, Colorado 80111
1-877-694-4015

Plan administration and ERISA rights

This chapter contains important legal information about the administration of your Ben E. Keith Company benefit plans, including:

- As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
- THE HIPAA privacy notice in this chapter describes how medical information about you may be used and disclosed and how you can get access to this information.
- The Medicare notice in this chapter explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll.
- The Medicaid/Children's Health Insurance Program (CHIP) notice explains special enrollment and premium assistance rights for individuals eligible for these programs.
- The name of the Plan, Plan numbers, and funding types for each plan.
- Your rights as a Plan participant

To find:	Go to or call:
An online version of this **Plan administration and ERISA rights** chapter	bek.family under the **Resources** section, accessible through the menu
Information about the administration of your benefit plans or your rights as a Plan participant.	Contact the Ben E. Keith Benefits Team at benefits@benekeith.com or 1-817-877-5700

The Ben E. Keith Company. maintains the Plan for the exclusive benefit of its eligible employees and their eligible family members. The Plan provides health and welfare benefits through the component benefit plans:

- Medical benefits, including prescription drugs.
- Dental insurance.
- Vision insurance.
- Company-paid basic life insurance.
- Supplemental employee life/AD&D insurance.
- Supplemental spouse and child life/AD&D insurance.
- Short-term disability insurance.
- Long-term disability insurance.

Each benefit program is summarized in its respective chapter of this SPD.

The terms and conditions of the Plan are set forth in these SPDs, and in the insurance policies and other welfare program documents incorporated into the Wrap Document. The Wrap Document, together with this book and the other incorporated documents, constitutes the written instrument under which the Plan is established and maintained. An amendment to an incorporated document, including this SPD, is considered an amendment to the Plan.

Company

As used in this Summary Plan Description, the terms "Company," "Ben E. Keith," or "Employer" refer to Ben E. Keith Company and any of its subsidiaries or affiliated companies that have adopted the benefit plans described in these Summary Plan Descriptions (SPDs) for their employees.

Plan Administrator and Plan Sponsor
The Plan Administrator and Plan Sponsor for the benefit plans described in this Summary Plan Description is:

Ben E. Keith Company
601 E. 7th Street
Fort Worth, TX 76102
Phone number: 1-817-877-5700

Employer Identification Number
The Employer Identification Number (EIN) for Ben E. Keith Company is 75-0372230.

Type of Administration
The Plan is administered by the Plan Administrator. The Plan Administrator has delegated fiduciary responsibility for determinations of claims for benefits and appeals under the self-funded benefit components to third-party administrators. For insured benefit components, insurers have fiduciary responsibility for determinations of claims for benefits and appeals.

Each chapter in this SPD identifies the specific third party, including insurers that administer claims and appeals for the respective benefits.

The Plan Administrator (or its delegates, including third-party administrators and insurers deciding claims and appeals) has complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator (or a delegate) made pursuant to the Plan shall be final, conclusive and binding on all persons, and may not be overturned unless found by a court to be arbitrary and capricious. Benefits will be paid only if the Plan Administrator (or a delegate) determines in its sole discretion that the claimant is entitled to them.

Plan funding
Ben E. Keith Company may fund Plan benefits out of its general assets or through contributions made to the Health and Welfare Trust. Contributions also may be required by employees, in an amount determined by Ben E. Keith Company in its sole discretion. All assets of the Plan, including employee contributions and any dividends or earnings of the Plan, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan amendment or termination
Ben E. Keith Company reserves the right within its sole discretion to amend or terminate any benefit or provision under the Plan, at any time and for any reason, as it relates to any current, past, or future participant or beneficiary under the Plan.

Neither the Plan nor the benefits described in these SPDs can be orally amended. All oral statements and representations shall be without force or effect, even if such statements and representations are made by the Plan Administrator. even if such statements and representations are made by the Plan Administrator, a management employee of the Company, or a third-party administrator. Only written statements by the Plan Administrator shall bind the Plan.

Your rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, ERISA provides that all Plan participants shall be entitled to:

1. **Receive information about your Plan and benefits.**
   - Examine, without charge, at the Plan Administrator's office and at other specified facilities, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
   - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Administrator may make a reasonable charge for the copies.

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

2. Continue group health plan coverage.

- You have the right to continue health care coverage for yourself, your spouse, or your 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 SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. (See the COBRA notice on the following pages for more information.)
- You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage.
- The Plan's medical benefit component does not have a pre-existing condition exclusion.

3. 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 Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have the 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 materials from the Plan and do not receive them within 30 days, you can 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 can file suit in a state or federal court. Generally, you must complete the appeals process before filing a lawsuit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a lawsuit against the Plan.
- 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 can file suit in a federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court.
- The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

4. Assistance with your questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed at https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U. S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

You can also obtain certain publications about your rights under ERISA by calling the Employee Benefits Security Administration publications hotline at 1-866-444-3272 or by going to dol.gov/ebsa.

Agent for service of legal process
Legal process may be served on the Plan Administrator at the address shown previously or may be served on the trustee or insurance carrier for a plan (as applicable).

Not a contract of employment
You should be aware that your participation in the Ben E. Keith employee benefit plans described in these Summary Plan Descriptions does not mean that your employment with the Company is guaranteed for any length of time.

Plan document
These documents constitute the official plan documents for all of the self-insured component benefit plans which are included in these Summary Plan Descriptions. There are separate group insurance policies for each of the insured component benefit plans; however, the certificates of insurance outlining your coverage are included within these documents.

You can obtain a copy of the applicable insurance policy by contacting the Ben E. Keith Benefits Team via email at benefits@benekeith.com or at 1-817-877-5700.

This **Plan Administration** chapter of the SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA) with respect to the component benefit plans. This document supersedes any previous printed or electronic Summary Plan Description(s) or other benefit descriptions, and the benefit plan descriptions contained in this document will also govern over any conflicting oral representations concerning the benefits provided under any specific benefit plan or program. However, if there is a conflict between the terms of this document and the terms of a current certificate of insurance issued by the insurer of an insured component benefit plan, the terms of the current certificate of insurance will govern the benefits provided under that insured component benefit plan.

Plan continuance
Ben E. Keith Company reserves the right, in its sole discretion, to modify, change, revise, amend, or terminate any or all of the plans that are provided under the terms of the benefit plans described in this Summary Plan Description at any time, for any reason, and without prior notice.

No participant has the right to any benefits from a plan following its termination, except that no amendment or termination may deprive you or an eligible dependent of any of the benefits to which you or an eligible dependent is entitled under a plan which have become due and payable under the terms of the plan through the date of such amendment or termination.

Any material amendment or termination of a plan will be adopted by formal action taken by the Board of Directors of the Ben E. Keith Company.

Type of plan
The Ben E. Keith Company Medical, Dental, and Vision Plans are considered to be group health plans under current federal regulations.

The Ben E. Keith Company Life Insurance and Disability Insurance plans and Flexible Spending Account Plans are considered to be welfare plans under current federal regulations.

You should be aware that the following plans or programs are not the type of plans that are covered by the Employee Retirement Income Security Act of 1974 (ERISA):

- Dependent Care Flexible Spending Account.
- Health Savings Account (HSA).

Plan year
The Plan year for each of the benefit plans described in these Summary Plan Descriptions is the same as the calendar year.

Non-alienation of benefits
For the protection of your interests and those of your dependents, your benefits under the benefit plans described in these Summary Plan Descriptions cannot be assigned and are not subject to garnishment or attachment, except to the extent permitted by law.

Plan name	Plan number	Funding status	Policy number
Ben E. Keith Company Medical Plan (including prescription drugs)	502	This plan is funded in part by participant contributions and in part by the Company. It is self-insured by the Company. This plan is insured through a group policy issued by: UnitedHealthcare at 11000 Optum Circle Eden Prairie, MN 55344 and Optum Rx at 2300 Main Street, Irving, CA 92614	*UnitedHealthcare and Optum Rx* 702898
Ben E. Keith Company BlueCross BlueShield Medical Plan (For Southeast Division and Kelley Manufacturing)	501	This plan is funded in part by participant contributions and in part by the Company. It is fully insured by the Company. The plan is insured through a group policy issued by BlueCross BlueShield of Alabama at 450 Riverchase Parkway East, P.O. Box 995, Birmingham, AL 35298	*BlueCross BlueShield* 35537
Ben E. Keith Company Flexible Spending Account Plan	502	This plan is funded in entirely by participant contributions. It is self-insured by the Company. The plan is insured through a group policy issued by United Healthcare Services, Inc. at 9900 Bren Road East, Minnetonka, MN 55343	*United Healthcare Services* 702898
Ben E. Keith Company Dental Plan	502	This plan is funded in part by participant contributions and in part by the Company. It is fully insured by the Company. This plan is insured through a group policy issued by: Cigna Dental at 900 Cottage Grove Rd, Bloomfield, CT 06002	*Cigna Dental* 3344508
Ben E. Keith Company Vision Plan	502	This plan is funded in part by participant contributions and in part by the Company. It is fully insured by the Company. This plan is insured through a group policy issued by: Superior Vision at 11090 White Rock Road, Suite 175, Rancho Cordova, CA 95670	*Superior Vision* 03306001
Ben E. Keith Company Life and Accident Insurance Plan	502	Basic Life/AD&D Insurance is funded entirely by the Company. Supplemental Life and Voluntary AD&D Insurance is funded by participant contributions. This plan is insured through a group policy issued by: Lincoln Financial Group at 150 N Radnor Chester Rd, Radnor, PA 19087	*Lincoln Financial Group* LF0664
Ben E. Keith Company Group Long-Term Disability Insurance	502	This plan is funded entirely by the Company. It is fully insured by the Company. This plan is insured through a group policy issued by: Lincoln Financial Group at 150 N Radnor Chester Rd, Radnor, PA 19087	*Lincoln Financial Group* LF0664
Ben E. Keith Company Short-Term Disability Plan	502	This plan is funded entirely by the Company. It is self-insured by the Company. This plan is insured through a group policy issued by: Lincoln Financial Group at 150 N Radnor Chester Rd, Radnor, PA	*Lincoln Financial Group* LF0664
Employee Assistance Program		This plan is funded entirely by the Company. GuidanceResources® at guidanceresources.com or 1-866-517-1267	*Organization Web ID* BEK
Ben E. Keith Company Retirement Savings Plan	002	This plan is funded in part by participant contributions and in part by the Company. Empower Retirement at empowermyretirement.com or 1-833-235-7283	*Empower Retirement* Plan number 194593-01

2022 Notice of Creditable Coverage: BEK PPO Medical Plan

Please read this Notice carefully and keep it where you can find it. This Notice has information about prescription drug coverage under the Ben E. Keith PPO Medical Plan (the “BEK PPO Medical Plan”) and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug

coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

There are two important things you need to know about BEK PPO Medical Plan coverage and Medicare's prescription drug coverage:

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

2. Ben E. Keith has determined that the prescription drug coverage offered by the BEK PPO Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the BEK PPO Medical Plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your BEK PPO Medical Plan creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?
If you decide to join a Medicare drug plan, your Company coverage will not be affected. For most persons covered under the BEK PPO Medical Plan, the BEK PPO Medical Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about which plan pays first and which plan pays second, see the BEK PPO Medical Plan Summary Plan Description or contact Medicare.

If you decide to join a Medicare drug plan and drop your current PPO coverage, you may be able to re-enroll in a Ben E. Keith medical plan during a future Annual Enrollment or within 31 calendar days following a qualified life event.

When will you pay a higher premium (penalty) to join a Medicare drug plan?
You should also know that if you drop or lose your BEK PPO Medical Plan coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this Notice or your current prescription drug coverage…
See the BEK PPO Medical Plan Summary Plan Description or call the Benefits Team at 1-817-877-5700. **Note:** You'll receive this Notice each year and if your medical coverage changes. You may request a copy of this Notice at any time by calling the Benefits Team at 1-817-877-5700.

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

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

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

IMPORTANT! Keep this 2022 Notice of Creditable Coverage. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show whether you maintained creditable coverage and, therefore, whether or not you must pay a higher premium (a penalty).

Date of this Notice: October 1, 2021
Name of Entity: Ben E. Keith Company
Contact Phone Number: 1-817-877-5700

2022 Notice of Creditable Coverage: BEK HSA Medical Plan

Please read this Notice carefully and keep it where you can find it. This Notice has information about prescription drug coverage under the Ben E. Keith Health Savings Account Medical Plan (the "BEK HSA Medical Plan") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this Notice.

There are two important things you need to know about BEK HSA Medical Plan coverage and Medicare's prescription drug coverage:

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

2. Ben E. Keith has determined that the prescription drug coverage offered by the BEK HSA Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because the BEK HSA Medical Plan coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your BEK HSA Medical Plan creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?
If you decide to join a Medicare drug plan, your Company coverage will not be affected. For most persons covered under the BEK HSA Medical Plan, the BEK HSA Medical Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about which plan pays first and which plan pays second, see the BEK HSA Medical Plan Summary Plan Description or contact Medicare.

If you decide to join a Medicare drug plan and drop your current HSA coverage, you may be able to re-enroll in a Ben E. Keith medical plan during a future Annual Enrollment or within 31 calendar days following a qualified life event.

When will you pay a higher premium (penalty) to join a Medicare drug plan?
You should also know that if you drop or lose your BEK HSA Medical Plan coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as

long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this Notice or your current prescription drug coverage…
See the BEK HSA Medical Plan Summary Plan Description or call the Benefits Team at 1-817-877-5700. **Note:** You'll receive this Notice each year and if your medical coverage changes. You may request a copy of this Notice at any time by calling the Benefits Team at 1-817-877-5700.

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

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

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

IMPORTANT! Keep this 2022 Notice of Creditable Coverage. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show whether you maintained creditable coverage and, therefore, whether or not you must pay a higher premium (a penalty).

Date of this Notice: October 1, 2021
Name of Entity: Ben E. Keith Company
Contact Phone Number: 1-817-877-5700

Women's Health and Cancer Rights

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.

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.

This coverage will be subject to the provisions, limitations, exclusions, deductibles and coinsurance that apply to other medical and surgical benefits provided under the Ben E. Keith medical option in which you're enrolled. For more information, refer to your Summary Plan Description on bekbenefits.com or call UnitedHealthcare at 1-844-587-8503.

Newborns' and Mothers' Health Protection

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In addition, plans may not require that a provider obtain prior authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

For more information, refer to your Summary Plan Description on bekbenefits.com or call UnitedHealthcare at 1-844-587-8503.

HIPAA Special Enrollment Rights

If you're declining enrollment in a Ben E. Keith medical plan for yourself or your eligible family members (your spouse and children) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical plan if you or your family member(s) lose eligibility for that other coverage (or if the employer stops contributing toward your or your family members' other coverage). However, **you must request enrollment within 31 calendar days** after your or your family members' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new family member as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical option, provided you are eligible. However, **you must request enrollment within 31 calendar days** after the marriage, birth, adoption or placement for adoption.

If coverage is lost under your state Medicaid or a Children's Health Insurance Program (CHIP) plan, or you become eligible for premium assistance under your state Medicaid or CHIP plan, you may be able to enroll yourself and your eligible family members in a Ben E. Keith medical plan. **You must request enrollment within 60 calendar** days of the date of the event. (See the "Children's Health Insurance Program (CHIP)" Notice for more information.)

To request special enrollment, see your HR Manager or Office Manager or contact the Benefits Team at 1-817-877-5700.

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Ben E. Keith medical plan, we must allow you to enroll if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 calendar days of being determined eligible for premium assistance.

If you have questions about enrolling in a Ben E. Keith medical plan, see your HR Manager or Office Manager, or contact the Benefits Team at 1-817-877-5700. You can also contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your state for more information on eligibility.

Arkansas – Medicaid
http://myarhipp.com/

1-855-MyARHIPP (855-692-7447)

Colorado – Medicaid and CHP+
http://www.healthfirstcolorado.com/

1-800-221-3943/State Relay 711

CHP+: http://www.colorado.gov/pacific/hcpf/child-health-plan-plus

1-800-359-1991/State Relay 711

Health Insurance Buy-In:
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program

1-855-692-6442

Florida – Medicaid
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

1-877-357-3268

Kansas – Medicaid
http://www.kancare.ks.gov

1-800-792-4884

Louisiana – Medicaid

http://www.medicaid.la.gov or http://www.ldh.la.gov/lahipp
1-888-342-6207 (Medicaid)
1-855-618-5488 (LaHIPP)

Missouri – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

1-573-751-2005

Oklahoma – Medicaid and CHIP
http://www.insureoklahoma.org
1-888-365-3742

Texas – Medicaid
http://gethipptexas.com/
1-800-440-0493

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

or

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

General Notice of COBRA Continuation Coverage

You are receiving this notice because you, your spouse and/or dependents, if any, have recently become covered under the group health plan for Ben E. Keith Company.

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

This notice is intended to inform you of your rights and obligations under provisions of the COBRA law if you, your spouse and/or eligible dependents, if any, lose coverage due to a COBRA qualifying event in the future. Enclosed you will find a copy of your *Notice of Right to Elect COBRA Continuation Coverage*. It is important that you, your spouse and/or eligible dependents, if any, are aware of and understand your rights under COBRA. Please share this information with any family members that are covered under the employer's group benefit plan(s).

We have also enclosed a copy of the *Health Insurance Portability and Accountability Act (HIPAA) Notice* so you are also aware of your rights and obligations under the HIPAA law.

Once again, this notice is for **informational purposes only**. Your benefits through your employer have not been terminated or affected in any way.

UnitedHealthcare
P.O. Box 740221
Atlanta, GA 53008
Phone: 1-866-747-0048
Fax: 1-800-324-3195
cobra@uhcservices.com
uhcservices.com

What is COBRA continuation coverage?
On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. You, your spouse and dependent children, if any, should all take the time to read the entire notice carefully.

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

If you’re an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events happens:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than his or her gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

If a covered child of the employee is enrolled in the Plan pursuant to a qualified medical child support order (QMCSO) during the employee’s period of employment, he or she is entitled to the same rights under COBRA as if he or she were the employee’s dependent.

How is COBRA coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to

elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Your election rights
When the Plan Administrator or designed Plan Service Provider is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage (because of one of the events described above) to inform the Plan Administrator or the designated Plan Service Provider that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end.

Coverage rights
If you choose continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. Each covered person will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Maximum period of coverage
The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment (for reasons other than gross misconduct) or reduction in hours. In that case, the required continuation coverage period is 18 months. These 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as death, divorce, legal separation or Medicare entitlement) occur during that 18-month time period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

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

Disability
The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment.

To benefit from this extension, a qualified beneficiary must notify the Plan Administrator or designated Plan Service Provider of the disability determination on or before 60 days from the COBRA start date, and before the end of the original 18-month period. If you do not notify the Plan Administrator or designated Plan Service Provider within the required period of time, you may lose your right to the extension.

The affected individual must also notify the Plan Administrator or designated Plan Service Provider within 30 days of any final disability determination that the individual is no longer disabled. Coverage will end on the first of the month, following at least 30 days after the date of the Social Security final disability determination letter.

California state residence
Under California law, you may be eligible for a state mandated extension of benefits after your federally mandated COBRA period expires. California state laws allow an extension of COBRA benefits to a total of 36 months from the date of your qualifying event to qualified beneficiaries who begin COBRA coverage on or after January 1, 2003. You will be notified of this extension at the conclusion of your original COBRA coverage.

Flexible Spending Account or Medical Reimbursement Account
If you are participating in the Company's Flexible Spending Account or Medical Reimbursement Account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

1. You will be allowed to continue coverage for the remainder of the current Plan year if you have a balance remaining in your account at the time of your termination or reduction in hours;
2. You will not be able to receive reimbursements in excess of your original election amount in the account; and
3. You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

You must give notice of some qualifying events
Under the law, the employee or a family member has the obligation to inform the Plan Administrator or Plan Service Provider, at the address on this form, of a divorce, legal separation, or a child losing dependent status within 60 days of the date of the event. The employer has the responsibility to notify the Plan Administrator or designated Plan Service Provider of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage. If you fail to notify the Plan Administrator or the designated Plan Service Provider within 60 days, you may lose your right to continuation coverage.

Adding dependents to COBRA coverage
A child who is born to or adopted by the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator or designated Plan Service Provider of the birth or adoption.

Expiration of COBRA coverage
The law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The company no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered – after the date he or she elects COBRA coverage – under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Limits to pre-existing conditions
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows:

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Insurance premiums
Under the law, you may have to pay all or part of the premium for your continuation coverage. You may also be required to pay a 2% administration fee above the cost of the premiums. If you are disabled, you may be required to pay 150% of the premium during the 11-month extension period.

Grace period
There is a grace period off 30 days for payment of the regularly scheduled premium.

Conversion coverage
At the end of the 18-month, 29-month, or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided a conversion health plan is available to active employees. Please read your health plan benefits booklet or Summary Plan Description regarding any option for conversion coverage after the expiration of COBRA coverage. If there is an option for conversion to an individual policy, follow the instructions provided to apply for the coverage, as it would be separate coverage, and would not simply be an extension of COBRA coverage.

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

Keep your Plan informed of address changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Valued plan participants

Ben E. Keith Company and the Health & Wellness Plan respect the dignity of each individual who participates in the Plan.

The Plan does not discriminate on the basis of race, color, national origin, sex, age, or disability and strictly prohibits retaliation against any person making a complaint of discrimination. Additionally, we gladly provide our participants with language assistance, auxiliary aids and services at no cost. We value you as our participant and your satisfaction is important to us.

If you need such assistance or have concerns with your Plan services, please call the number on the back of your Medical ID card. If you have any questions or concerns, please use one of the methods below so that we can better serve you.

Claims questions and assistance

Contact the Plan's Claims Administrator if you need assistance with filing, status or payment of your benefit claim.

If your claim for benefits is denied, the Claims Administrator will provide you with written notification of the denial and the reasons for it. The procedures for resolving claim disputes and appealing a denied claim are included in each Plan's chapter. The following chart contains the Claims Administrator, by plan or program.

Plan or program	Claims Administrator	Claims procedures
BEK PPO Medical Plan BEK HSA Medical Plan	United Healthcare Services, Inc. P.O. Box 30555 Salt Lake City, UT 84130-0555 myuhc.com or 1-844-587-8503	**BEK Medical Plans & prescription drugs** chapter
BEK Dental Plan	Cigna Dental P.O. Box 188037 Chattanooga, TN 37422 mycigna.com or 1-800-CIGNA24 (1-800-244-6224)	**BEK Dental Plan** chapter
BEK Vision Plan	Superior Vision superiorvision.com or 1-800-507-3800	**BEK Vision Plan** chapter
Flexible Spending Accounts For health care and dependent care	UnitedHealthcare Services, Inc. 9900 Bren Road East Minnetonka, MN 55343 myuhc.com or 1-800-755-2648	**Flexible Spending Accounts** chapter
BEK employee, spouse and child Life/AD&D	Lincoln Financial Group mylincolnportal.com Company code **BEKCO** 1-888-408-7300	**BEK Life and Accidental Death & Dismemberment Insurance (Life/AD&D)** chapter
Short-term Disability	Lincoln Financial Group mylincolnportal.com Company code **BEKCO** 1-888-408-7300	**Short-term Disability (STD)** chapter
Long-term Disability	Lincoln Financial Group mylincolnportal.com Company code **BEKCO** 1-888-408-7300	**Long-term Disability (LTD)** chapter
Employee Assistance Program	GuidanceResources® guidanceresources.com Organization Web ID **BEK** 1-866-517-1267	**Employee Assistance Program** chapter
BEK Retirement Savings Plan Profit Sharing and 401(k)	Empower empowermyretirement.com 1-833-BEK-SAVE (1-833-235-7283)	**The BEK Retirement Savings Plan** chapter
Pension Plan	Aon Retirement Services ypr.aon.com/benekeith 1-844-870-0335	**Pension Plan** Summary Plan Description

Definitions

Active work, actively at work, active service: You are actively performing all the regular duties of your job for Ben E. Keith on a scheduled work day. You will be considered actively at work on a day that is not one of your scheduled work days if you were actively at work on the preceding scheduled work day.

Allowed amount or allowable expense: The amount paid for a covered service. This amount is limited to the lesser of the provider's charge or the amount of that charge that is determined by the insurer to be allowable depending on the type of provider utilized and the state in which services are rendered.

Alternate facility: A health care facility that is not a hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services;
- Emergency health services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Ancillary services: items and services provided by non-network physicians at a network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Plan;
- Provided by such other specialty practitioners as determined by the Plan; and
- Provided by a non-network physician when no other network physician is available.

Annual deductible or deductible: The amount you pay each year for eligible charges before the insurer pays a portion of your covered expenses.

Annual Enrollment: The period usually in the fall of each year, during which employees make benefit elections for the next Plan year.

Behavioral health benefits: The benefits for mental health and substance abuse, including alcohol and drug abuse.

Behavioral health facility: With respect to behavioral health benefits, a medical facility that provides:

- 24-hour inpatient care.
- Partial hospitalization or out-patient care that requires six to eight hours of service per day, five to seven days per week.
- Intensive outpatient care that requires two to four hours of service per day, three to five days per week.
- A residential treatment facility.

Brand-name drug: A drug manufactured by a single manufacturer that has been evaluated for safety and effectiveness when compared with similar drugs treating the same condition and identified for inclusion on the covered brand-name drug list.

Catch-up contributions: Allow people age 50 or older to save more in their 401(k)s and individual retirement accounts (IRAs) than the usual annual contribution limits set by the IRS.

COBRA: The Consolidated Omnibus Budget Reconciliation Act, which allows employees and their eligible dependents who experience a loss in coverage due to a qualifying event to continue medical, dental and vision coverage.

Coinsurance: The amount you pay for eligible expenses under plans after you've met your annual deductible.

Company: Ben E. Keith Company and its participating subsidiaries.

Contact lenses, elective: Elective contact lenses chosen by the insured to wear instead of eyeglasses for reasons of comfort or appearance.

Contact lenses, non-elective: Non-elective contact lenses refer to contact lenses that are prescribed solely for the purpose of correcting one (1) of the following medical conditions. These conditions prevent the insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses. Reimbursement of non-elective contact lenses will be considered as payment in full if utilizing the services of an in-network provider. This benefit provides coverage for the materials only. It does not include the contact lens fitting fee.

Coordination of Benefits (COB): When two benefit plans insure the same participant and coordinate coverage, the process of designating one plan as primary and the other plan as secondary.

Copay or copayment: A set dollar amount, that you are required to pay for certain covered services such as prescriptions or doctor or hospital visits.

Covered expenses: Charges for procedures, supplies, equipment or services covered under the medical plan that are:

- Medically necessary;
- Not in excess of the maximum allowable charge;
- Not excluded under the Plan; and
- Not otherwise in excess Plan limits.

Custodial care: Services in a facility or home to maintain a person's present state of health, which cannot reasonably be expected to significantly improve.

Disability or disabled: If you are unable to perform your own job duties because of a non-work-related accident or illness and under continued care by a physician.

Eligibility waiting period: The time between an employee's hire date and the date the employee is eligible to enroll for benefits.

Evidence of Insurability (EOI), also called proof of good health: Evidence of your healthy condition for certain amounts of life/AD&D insurance. Includes completing a questionnaire your or your spouse's medical history. If required, a questionnaire will be made available to you when you enroll in life/AD&D benefits.

Experimental and/or investigational: Any treatment, procedure, equipment, drugs, drug usage, or supplies that do not meet generally accepted standards of medical practice.

Health Savings Account (HSA): A high-deductible health plan for non-Southeast Division and Kelley Manufacturing employees that comes with a tax-fee Company contribution in a savings account. You may also make your own tax-free contributions (up to annual IRS limits) to this account to be used for paying expenses at doctor's office, pharmacy and other health care facilities, and dental or vision care.

HIPAA: Health Insurance Portability and Accountability Act of 1996, which protects the privacy of personal health information.

Hospital: An institution where sick or injured individuals are given medical or surgical care. The hospital must be a licensed and legally operated acted care general facility that provides:

- Room and board and nursing services for all patients on a 24-hour basis, with a staff or one or more doctors available at all times, and
- On-premise facilities for diagnosis, therapy and major surgery.

A hospital is an institution that is not primarily a nursing home, rest home, convalescent home, institution for treating substance abuse or custodial care institution.

In-network provider: Health care provider who has entered into an agreement with the Plan Administrator to provide covered services or materials at an agreed to cost. When an in-network provider is used, the insured will generally incur less out-of-pocket cost for the services rendered.

Initial enrollment period: The first time you are eligible to enroll for benefits under the Plan. See the *Eligibility and enrollment* chapter for additional information.

Leave of absence: Provides employees with needed time away from work while maintaining eligibility for benefits and continuity of employment. To accommodate situations that necessitate absence from work, Ben E. Keith provides three types of leave: (1) Family and Medical Leave Act (FMLA); (2) personal; and (3) military.

The decision to grant a request for leave shall be based on applicable laws, the nature of the request, the effect on work requirements, and consistency with the policy guidelines and procedures.

Maximum allowable charge (MAC): The maximum amount the plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies or benefits covered by the Plan.

Maximum plan allowance (MPA): The maximum reimbursable charge (MRC) for covered dental services is determined based on the lesser of:

- The provider's normal charge for a similar service or supply; or
- The policyholder-selected percentile of charges allowed by payers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna and updated annually. If sufficient data is unavailable in the database for that geographic area to determine the maximum reimbursable charge, then state, regional or national data may be used. If sufficient data is unavailable in the database, then data in the database for similar services may be used.

Medically necessary or medical necessity: Procedures, supplies, equipment or services that are determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion, to be:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
2. Provided for the diagnosis or direct care and treatment of your medical condition;
3. In accordance with standards of good medical practice accepted by the organized medical community;
4. Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
5. Not "investigational"; and,
6. Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary.

Non-network providers, out-of-network provider: Health care providers that do not have a written agreement with the Plan Administrator to provide services at discounted rates.

Out-of-pocket maximum: The most you will pay each year for eligible network services, including prescriptions.

Premium: The amount you pay for the benefits you choose, generally out of each paycheck.

Preventive or routine: Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

Qualified medical expense: An expense that meets the definition of medical expenses under Internal Revenue Code Sec. 213(d). Examples are provided in IRS Publications 502, *Medical and Dental Expenses.*

Qualified Medical Child Support Order (QMCSO): A final court or administrative order requiring an employee to provide health care coverage for eligible dependents under the Plan.

Residential treatment: Treatment in a facility which provides mental health services or substance use disorder services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs;
- It provides a program of treatment under the active participation and direction of a physician and approved by the Mental Health/Substance Use Disorder Administrator;
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board;
  - Evaluation and diagnosis;
  - Counseling; and
  - Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a hospital is considered a hospital.

Specialty drug: Specialty drugs are those pharmaceuticals that target and treat specific chronic or genetic conditions. Specialty drugs includes biopharmaceuticals (bioengineered proteins), blood-derived products and complex molecules.

Spouse: An individual to whom you are legally married.

Third Party Administrator (TPA): A third party that makes claims and internal appeals determinations under the Plan, pursuant to a contractual arrangement with the Plan. Third Party Administrators process your claims and internal appeals with respect to the Plan's self-funded medical benefits. Third Party Administrators do not insure any benefits under the Plan.

Total disability or totally disabled: Total disability means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated.

The determination of whether you are disabled will be made by Lincoln Financial Group on the basis of medical evidence. Objective medical evidence consists of facts and findings, including but not limited to, X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from you physician; and you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

Urgent care: Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Vesting: The point in time when you own the Company's matching contributions (and earnings) in your BEK 401(k) account. You are always 100% vested in your personal contributions. Money in your Profit Sharing account is vested depending on your years of service. Refer to **The BEK Retirement Savings Plan** chapter for additional information on vesting.

It's easy to enroll, here's how.

You'll need your user name (employee ID) and password to get started. Forgot your password? Send an email to servicedesk@benekeith.com to reset your password.

1. **Login at dayforcehcm.com**
   - Enter Company code **BEKCO**, your user name (employee ID) and password.
   - Click **Benefits** then **Start Enrollment**.
   - Review the Welcome screen and then select **Next**.

2. **Review and update your dependents and beneficiaries**
   - Click **View/Edit**.
   - Click + to add a dependent and/or beneficiary.
   - Select **Next** to begin your enrollment session.

3. **Choose (or waive) coverage in each benefit**
   - Your current coverage (if any) will be noted by a green check mark.
   - Certify tobacco usage and whether you have a working spouse.
   - If prompted, go back and choose or waive coverage in each benefit.

4. **Submit and save/print your enrollment confirmation**

View your selected coverage any time on dayforcehcm.com

Covering your spouse or children?

If you want to enroll your dependents in medical, dental, vision and/or spouse/child life/AD&D coverage, you will be asked to provide documentation (like a marriage license or birth certificate) that verifies they are eligible for coverage. Make sure to return the requested documents by the deadline. Find a list of acceptable dependent eligibility documents in the **Resources** > **Who is eligible and how to enroll** section of bek.family.

If you have questions about...	Go to or call:
Eligibility and enrollment • **When you're eligible for benefits** • **How and when to enroll**	Go to the **Resources** section of bek.family or contact the Benefits Team at benefits@benekeith.com or call 1-817-877-5700
Medical claims or to find a network provider	UnitedHealthcare (UHC) at myuhc.com or call 1-844-587-8503
Health Savings Accounts	Optum Health at optumbank.com or call 1-844-326-7967
Prescription drug providers	UnitedHealthcare (UHC) at myuhc.com or call 1-844-587-8503
Dental claims	Cigna at mycigna.com or call 1-800-CIGNA24 (1-800-244-6224)
Disability insurance • **Short-term disability** • **Long-term disability**	Lincoln Financial Group at mylincolnportal.com Company code **BEKCO** or call 1-888-408-7300
Flexible Spending Accounts	UnitedHealthcare (UHC) at myuhc.com or call 1-866-755-2648
Life and Accidental Death and Dismemberment Insurance	Lincoln Financial Group at mylincolnportal.com Company code **BEKCO** or call 1-888-408-7300
Employee Assistance Program	GuidanceResources at guidanceresources.com Organization Web ID **BEK** or call 1-866-517-1267
Retirement Savings Plan • **Profit Sharing** • **401(k)**	Empower Retirement at empowermyretirement.com or 1-833-BEK-SAVE (1-833-235-7283). Spanish speaking representatives are available.
COBRA	UnitedHealthcare Benefits Services at uhcservices.com or 1-866-747-0048

Visit bek.family any time for more information

The purpose of this book, called the Summary Plan Description (SPD), is to describe and explain benefits plans available to employees of Ben E. Keith Company and its subsidiaries. The SPD is intended only to help you understand the benefit plans available to you and can in no way modify the actual terms and provisions as specified in the legal documents that define the benefit plans. If there are differences between the information contained in the SPD and the provisions of the legal documents, the legal documents always govern. Legal documents include the official Plan document, trust agreements, and insurance contracts. You may request a copy of these legal documents by contacting the Plan Administrator. Although the Company established the benefits plans with the intention of maintaining them indefinitely, the Company reserves the right to amend, modify and/or terminate the plans, or any particular plan, at any time.

Benefits are provided to employees and their eligible dependents based on the information the Company may request over the phone, in writing or online. The Company may ask you to provide original documentation for the purpose of verification before granting benefits. The Company may also ask you to sign a release authorizing the Company to solicit the required documentation and/or information from a designated third party. Providing false information may result in exclusion from (i.e., loss of eligibility for) all Company-sponsored welfare benefits plans and/or disciplinary action against you in accordance with the Company's policies.