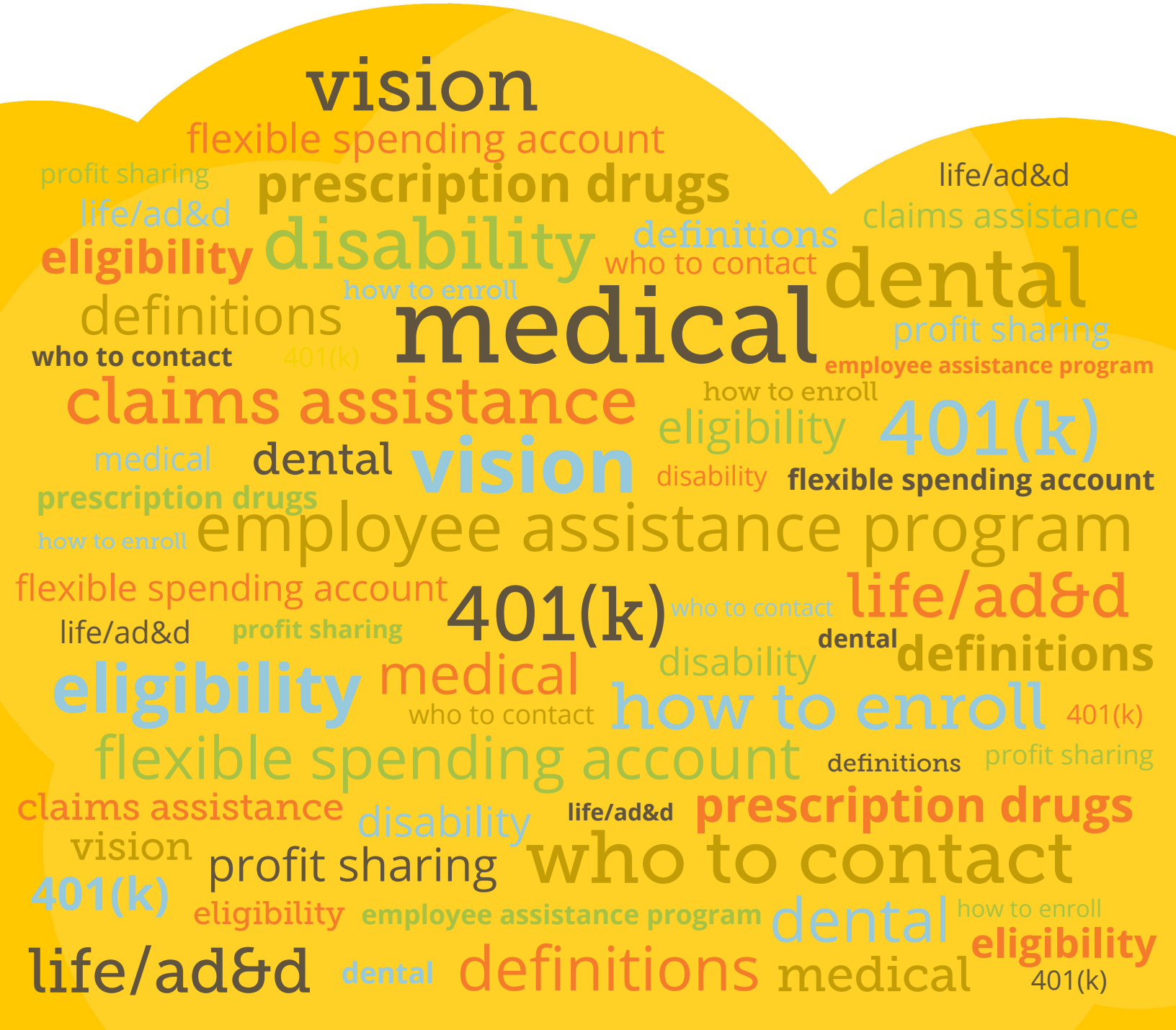
Ben E. Keith Company
2022 Summary Plan Descriptions

For Southeast Division and Kelley Manufacturing



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
Comprehensive medical coverage with the BEK BCBS Medical Plan, including prescription drug benefits and wellness programs.

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

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.

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.

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 30 days of employment. Otherwise, you must wait until the next Annual Enrollment period.
- 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 30 days.

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 • 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 • 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 30 days of continuous employment.
- **Salaried employees**. Coverage begins on the first day of the month that is on or after the date that he or she completes 30 days of continuous employment.
- **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 BCBS Medical Plan** chapter for more information about the certification of a disabled child.

IMPORTANT! You must enroll within 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 30 days of employment, 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.

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 30 days of enrolling him or her for coverage.

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 30 days 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.

- **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)
- 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. If you want to participate in these accounts, you must enroll and elect your yearly contribution amount during each Annual Enrollment period.

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.).

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 BCBS Medical Plan

The following provisions of this chapter contain a summary in English of your rights and benefits under the Plan. If you have questions about your benefits, please contact Customer Service at 1-800-292-8868. If needed, request a translator and one will be provided to assist you in understanding your benefits.

Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el Plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-800-292-8868. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.

The Plan is intended to help you and your covered dependents pay for the costs of medical care. The Plan does not pay for all of your medical care. For example, you may be required to contribute through payroll deduction before you obtain coverage under the Plan. You may also be required to pay deductibles, copayments, and coinsurance.

We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

BlueCare Health Advocate
By being a member of the Plan, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you, and much more. To find out more or to contact your BlueCare Health Advocate, call Customer Service at the number on the back of your Member ID card.

Grandfathered status under the Affordable Care Act
Your group believes this Plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the contact information in the *Administrative information* section of this chapter. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Receipt of medical care
Even if the Plan does not cover benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Generally, after-hours care is provided by your physician. They may have a variety of ways of addressing your needs. You should call your physician for instructions on how to receive medical care after the physician’s normal business hours, on weekends and holidays, or to receive non-emergency care for a condition that is not life threatening, but requires medical attention.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room.

Although you are not required to have a primary care physician, it is a good idea to establish a relationship with one. Having a primary care physician has many benefits, including:

- Seeing a physician who knows you and understands your medical history.
- Having someone you can count on as a key resource for your healthcare questions.
- Help when you need to coordinate care with specialists and other providers.

Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics. Find a physician in your area by visiting AlabamaBlue.com/FindADoctor.

If you need to see a specialist or behavioral health provider, you can contact their office directly to make an appointment. If you choose to see a specialist or behavioral health provider in our BlueCard PPO or Blue Choice Behavioral Health networks, you will have in-network benefits for services covered under the Plan. If you choose to see an out-of-network specialist or behavioral health provider, your benefits could be lower.

Beginning of coverage

The *Eligibility* section of this chapter will tell you what is required for you to be covered under the Plan and when your coverage begins.

Limitations and exclusions

In order to maintain the cost of the Plan at an overall level that is reasonable to all Plan members, the Plan contains a number of provisions that limit benefits. There are also exclusions that you need to pay particular attention to as well. These provisions are found through the remainder of this chapter. You need to be aware of these limits and exclusions to determine if the Plan will meet your healthcare needs.

Medical necessity and precertification

The Plan will only pay for care that is medically necessary and not investigational, as determined by us. “Medical necessity” is used to help the Plan determine whether a particular service or supply will be covered. When possible, we develop written criteria, called medical criteria, that we use to determine medical necessity. We publish these standards at AlabamaBlue.com/providers/policies. We base these on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that are available to the medical community and to Plan participants. We do this so that you and your providers will know in advance, when possible, what the Plan will pay for. If a service or supply is not medically necessary according to one of our published medical criteria policies, the Plan will not pay for it. If a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be medically necessary only if we determine that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not “investigational”; and,
- 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. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when we make medical necessity determinations, we are making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

In some cases, the Plan requires that you or your treating physician pre-certify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the Plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered. The *Medical necessity and precertification* section of this chapter explains when precertification is required and how to obtain precertification.

In-network benefits

The Plan tries to manage your care costs through negotiated discounts with in-network providers. As you read the remainder of this chapter, you should pay attention to the type of provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the Plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing.

As one example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the Plan. Additionally, out-of-network providers have not contracted with us or any Blue Cross and/or Blue Shield Plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the Plan.

Examples of the Plan's Alabama in-network providers are:

- BlueCard PPO.
- Participating Hospitals.
- Hospital Choice Network.
- Preferred Outpatient Facilities.
- Participating Ambulatory Surgical Centers.
- Participating Renal Dialysis Providers.
- Preferred Medical Doctors (PMD).
- Preferred Medical Laboratories.
- Bariatric Surgery Network.
- Select Lab Network.
- Blue Choice Behavioral Health Network.
- Expanded Psychiatric Services.
- Participating Chiropractors.
- Participating Physician Assistants.
- Participating Nurse Practitioners.
- Preferred Occupational Therapists.
- Preferred Physical Therapists.
- Preferred Speech Therapists.
- Blue Achievement- Knees and Hips Network.
- Participating CRNA.
- Participating Ground Ambulance.
- Participating Licensed Registered Dietitian Network.
- Pharmacy Vaccine Network.
- AccessONE Network.
- Prime Participating Pharmacy Network.
- ValueONE Network.
- PreferredONE Retail Network.
- PreferredONE ESN Network.
- ChoiceONE Retail Network.
- ChoiceONE ESN Network.
- Pharmacy Select Network.
- Preferred DME Supplier.
- Participating Air Medical Transport.
- Preferred Home Health Network.
- Preferred Home Infusion Network.

To locate Alabama in-network providers, go to AlabamaBlue.com/FindADoctor.

1. In the search box, you can select the category you would like to search: doctor, hospital, dentist, pharmacy, or keep on "All Categories" to search all. Type in the provider's name to search or leave blank to see all results.
2. In the "Network or Plan" section, use the drop down menu to select a specific provider network.

Search tip: If your search returns zero results, try expanding the number in the "Distance" drop-down.

A special feature of your Plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield Plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit AlabamaBlue.com/FindADoctor and log into your *my*BlueCross. Search for a specific provider by typing their name in the "Search Term" box or click Search to see all in-network providers for your Plan.

To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield Plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield Plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield Plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross and/or Blue Shield Plan where services are rendered. The local Blue Cross and/or Blue Shield Plan will then forward the claims to us for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the Plan or is not covered under the contract between the provider and Blue Cross and Blue Shield of Alabama or the local Blue Cross and/or Blue Shield Plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the plan, such as other covered services.

Relationship between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association
Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

Claims and appeals
When you receive services from an in-network provider, your provider will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with us for reimbursement under the terms of the Plan. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review. Thereafter, you may have the right to an external review by an independent external reviewer. The provisions of the Plan dealing with claims or appeals are found further on in this chapter.

Changes in the Plan
From time to time it may be necessary to change the terms of the Plan. The rules we follow for changing the terms of the Plan are described later in the *Changes in the Plan* section of this chapter.

Termination of coverage
The *Eligibility* section of this chapter tells you when coverage will terminate under the Plan. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the Plan or your coverage termination. In some cases, you will have the opportunity to buy COBRA coverage after your group coverage terminates. COBRA coverage is explained in detail in the **Plan administration and ERISA rights** chapter of this SPD.

Respecting your privacy
To administer this Plan, we need your medical information from physicians, hospitals and others. To decide if your claim should be paid or denied or whether other parties are legally responsible for some or all of your expenses, we need records from healthcare providers and other plan administrators. By applying for coverage and participating in this Plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need in order to administer this Plan or to perform any function authorized or permitted by law. To further direct all other persons to release all records to us about your minor dependents that we need to administer the Plan If you or any provider refuses to provide records, information or evidence we request within reason, we may deny your benefit payments.

You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law. Additionally, we may use or disclose your personal health information for treatment, payment or healthcare operations, or as permitted or authorized by law pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have prepared a privacy notice that explains our obligations and your rights under the HIPAA privacy regulations. To request a copy of our notice or to receive more information about our privacy practices or your rights, please contact us at the following address:

Blue Cross and Blue Shield of Alabama Privacy Office
P.O. Box 2643
Birmingham, Alabama 35202-2643

You may also go to AlabamaBlue.com for a copy of our privacy notice.

Your rights
As a member of the Plan, you have the right to:
- Receive information about us, our services, in-network providers, and your rights and responsibilities.

- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the Plan provides.
- Make recommendations regarding our member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service number on the back of your Member ID card.

Your responsibilities

As a member of the Plan, you have the responsibility to:

- Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the information provided in this chapter the coverage or lack thereof under your Plan.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Eligibility

You are eligible to enroll in this Plan if all of the following requirements are satisfied:

- You are an employee and are treated as such by your group. Examples of persons who are not employees include independent contractors, board members, and consultants.
- Your group has determined that you work on average 30 or more hours per week (including vacation and certain leaves of absence that are discussed in the section dealing with termination of coverage) in accordance with the Affordable Care Act.
- You are in a category or classification of employees that is covered by the plan.
- You meet any additional eligibility or participation rules established by your group.
- You satisfy any applicable waiting period, as explained below.

You must continue to meet these eligibility conditions for the duration of your participation in the Plan.

Eligible dependents

Your eligible dependents are:

- Your spouse
- Your married or unmarried child up to age 26.
- Your unmarried, incapacitated child who (1) is age 26 and over; (2) is not able to support himself; and (3) depends on you for support, if the incapacity occurred before age 26.

The child may be the employee's natural child; stepchild; legally adopted child; child placed for adoption; or eligible foster child. An eligible foster child is a child that is placed with you by an authorized placement agency or by court order.

You may cover your grandchild only if you are eligible to claim your grandchild as a dependent on your federal income tax return.

You may not cover your grandchild unless your grandchild is your adopted child, a child placed for adoption or your eligible foster child.

Waiting period for coverage under the Plan

There is a waiting period under the Plan. Coverage begins on the 1st day of the month following 30 days of employment. Under federal law, any waiting period established by your group cannot be longer than 90 days.

Coverage will begin on the date specified in the *Beginning of coverage* section of this **BEK BlueCross BlueShield Medical Plan** chapter, but in no event later than the 91st day in which you first meet the eligibility or participation rules established by your group (other than any applicable waiting period).

Applying for Plan coverage
To apply for coverage, go to dayforcehcm.com and complete an enrollment session. You must provide the names and requested information for all eligible dependents that you would like to cover.

If we accept your application, you will receive a Member ID card. If we decline your application, we will refund any fees paid.

Beginning of coverage
Annual Enrollment period. If you do not enroll during a regular enrollment or a special open enrollment period described below, you may enroll only during your group's Annual Enrollment period, if any. Your coverage will begin on the date specified by your group following your enrollment.

Regular enrollment period. If you apply within 30 days after the date on which you meet the Plan's eligibility requirements (including any applicable waiting periods established by your group), your coverage will begin as of the date thereafter specified by your group but in no event later than the 91st day in which you first meet the eligibility requirements established by your group (other than any applicable waiting periods). If you are a new employee, coverage will not begin earlier than the first day on which you report to active duty.

Special enrollment period for individuals losing other minimum essential coverage. An employee or dependent (1) who does not enroll during the first 30 days of eligibility because the employee or dependent has other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or minimum essential coverage by other health plans which ended due to "loss of eligibility" (as described below) or failure of the employer to pay toward that coverage, and (3) who requests enrollment within 30 days of the exhaustion or termination of coverage, may enroll in the Plan. Coverage will be effective no later than the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment.

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment, failure of your employer to offer minimum essential coverage to you, and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage for fraud or intentional misrepresentation of a material fact.

Special enrollment period for newly acquired dependents. If you have a new dependent as a result of marriage, birth, placement for adoption, adoption, or placement as an eligible foster child, you may enroll yourself and/or your spouse and your new dependent provided that you request enrollment within 30 days of the event. The effective date of coverage will be the date of birth, placement for adoption, adoption, or placement as an eligible foster child. In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment.

Special enrollment period related to Medicaid and SCHIP. An employee or dependent who loses coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage may enroll in the Plan provided that the employee or dependent requests enrollment within 60 days of the termination of coverage. An employee or dependent who becomes eligible for premium assistance under Medicaid or SCHIP for coverage under the Plan may also enroll in the Plan provided that the employee or dependent requests enrollment within 60 days of becoming eligible for such premium assistance. Coverage will be effective no later than the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment.

Qualified Medical Child Support Orders
If the group (the plan administrator) receives an order from a court or administrative agency directing the Plan to cover a child, the group will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the Plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The group has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting your group.

The Plan will cover an employee's child if required to do so by a QMCSO. If the group determines that an order is a QMCSO, we will enroll the child for coverage effective as of a date specified by the group, but not earlier than the later of the following:

- If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.
- If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the group may increase the employee's payroll deductions. During the period the child is covered under the Plan as a result of a QMCSO, all Plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the QMCSO is in effect we will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. We will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the Plan. We will also send claims reports directly to the child's custodial parent or legal guardian.

Relationship to Medicare

You must notify your group when you or any of your dependents become eligible for Medicare. Except where otherwise required by federal law (as explained below), the Plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this Plan is secondary to Medicare in accordance with the rules explained below, this Plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible. For more information about how this Plan coordinates with Medicare, please see the *Coordination of Benefits* section of this chapter.

In determining the size of your group for purposes of the following provisions, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if your group participates in an association plan.

Individuals age 65 and older. If your group employs 20 or more employees and if you continue to be actively employed when you are age 65 or older, you and your dependents will continue to be covered for the same benefits available to employees under age 65. In this case, the Plan will pay all eligible expenses primary to Medicare. If you are enrolled in Medicare, Medicare will pay for Medicare eligible expenses, if any, not paid by the Plan.

If both you and your spouse are over age 65, you may elect to enroll in Original Medicare or a Medicare Advantage plan and/or a Medicare Part D prescription drug plan and disenroll completely from the Plan. This means that you will have no benefits under the Plan. If you enroll in Original Medicare, you may also purchase a Medicare Supplement contract. In addition, the group is prohibited by law from purchasing your Medicare Supplement contract for you or reimbursing you for any portion of the cost of the contract. If you enroll in a Medicare Advantage plan, you may not purchase a Medicare Supplement contract.

If you are age 65 or older, considering retirement, or have another qualifying event under COBRA, and think you may need to buy COBRA coverage after such qualifying event, review the *General Notice of COBRA Continuation Coverage* in the **Plan Administration and ERISA Rights** chapter of this SPD.

Disabled individuals. If you or a dependent is eligible for Medicare due to disability and is also covered under the Plan by virtue of your current employment status with the group, Medicare will be considered the primary payer (and the Plan will be secondary) if your group normally employed fewer than 100 employees during the previous calendar year. If your group normally employed 100 or more employees during the previous calendar year, the Plan will be primary and Medicare will be secondary.

End-stage renal disease. If you are eligible for Medicare as a result of end-stage renal disease (permanent kidney failure), the Plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility (regardless of the size of the group). Thereafter, Medicare will be primary and the Plan will be secondary.

Medicare Part D Prescription Drug Coverage
If the Plan does not provide "creditable" prescription drug benefits – that is, the plan's prescription drug benefits are not at least as good as standard Medicare Part D prescription drug coverage, you should enroll in Part D of Medicare when you become eligible for Medicare. Your group will tell you whether the Plan's prescription drug benefits are at least as good as Medicare Part D.

If you have any questions about coordination of your coverage with Medicare, please contact your group for further information. You may also find additional information about Medicare at medicare.gov.

Termination of coverage
Plan coverage ends as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

- The date on which the employee fails to satisfy the conditions for eligibility to participate in the Plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the *Leaves of absence* section below).
- For spouses, the date of divorce or other termination of marriage.
- For children, the date a child ceases to be a dependent.
- For the employee and his or her dependents, the date of the employee's death.
- Your group fails to pay us the amount due within 30 days after the day due.
- Upon discovery of fraud or intentional misrepresentation of a material fact by you or your group.
- Any time your group fails to comply with the contribution or participation rules in the Plan documents.
- When none of your group's members still live, reside or work in Alabama.
- On 30-days advance written notice from your group to us.

In all cases except the last item above, the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and all other employees in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

Leaves of absence
If your group is covered by the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the Plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to employers who employ 50 or more employees. You should contact your group to determine whether a leave qualifies as FMLA leave.

You may also continue your coverage under the Plan for up to 30 days during an employer-approved leave of absence, including sick leave. Contact your group to determine whether such leaves of absence are offered. If your leave of absence also qualifies as FMLA leave, your 30-day leave time runs concurrently with your FMLA leave. This means that you will not be permitted to continue coverage during your 30-day leave time in addition to your FMLA leave.

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should see your group for information about your rights to continue coverage under the Plan.

Cost sharing

Calendar year deductible

Calendar year deductible	$400 individual / $1,200 family
Calendar year out-of-pocket maximum	$1,500 individual / $4,500 family

The calendar year deductible is noted above. Within this chapter, you can learn more about when benefits are subject to the calendar year deductible. The calendar year deductible is the amount you or your family must pay for some medical expenses covered by the Plan before your healthcare benefits begin.

- The individual calendar year deductible must be satisfied on a per member per calendar year basis, subject to the family calendar year deductible maximum.
- The family calendar year deductible is an aggregate dollar amount. This means that all amounts applied toward the individual calendar year deductible will count toward the family calendar year deductible amount. Once the family calendar year deductible is met, no further family members must satisfy the individual calendar year deductible.
- Only one individual calendar year deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- In all cases, the deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

Calendar year out-of-pocket maximum

The calendar year out-of-pocket maximum is specified in the chart shown on the previous page. The calendar year out-of- pocket maximum generally applies to services or supplies that are subject to the calendar year deductible. There may be exceptions to this, depending upon specifications from your group. You may also call Customer Service if you have questions about payments that count towards the calendar year out-of-pocket maximum. Once the maximum has been reached, covered expenses of the type that count towards the maximum will be paid at 100% of the allowed amount for the remainder of the calendar year.

There may be many expenses you are required to pay under the Plan that **do not** count towards the calendar year out-of-pocket maximum, and that you must continue to pay even after you have met the calendar year out-of-pocket maximum. The following are some examples of expenses that **do not** count toward your out-of-pocket maximum:

- Out-of-network coinsurance on most services.
- Per admission deductibles.
- Copayments.
- Amounts paid for non-covered services or supplies.
- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges).
- Amounts paid for services or supplies in excess of any Plan limits (for example, a limit on the number of covered visits for a particular type of provider).
- Amounts paid as a penalty (for example, failure to pre-certify).

The calendar year out-of-pocket maximum applies on a per person per calendar year basis, subject to the family maximum.

The calendar year family out-of-pocket maximum is an aggregate dollar amount. This means that all amounts that count towards the individual calendar year out-of-pocket maximum will count towards the family aggregate amount. Once the family calendar year out-of-pocket maximum is met, affected benefits for all covered family members will pay at 100% of the allowed amount for the remainder of the calendar year.

Other cost sharing provisions

The Plan may impose other types of cost sharing requirements such as the following:

- **Per admission deductibles:** These apply upon admission to a hospital. Only one per admission deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- **Copayments:** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor's office.
- **Coinsurance:** Coinsurance is the amount that you must pay as a percent of the allowed amount.
- **Amounts in excess of the allowed amount:** As a general rule, the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with us or their local Blue Cross and/or Blue Shield Plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount. As one example, certain out-of-network facility claims may include very expensive ancillary charges (such as implantable

devices) for which no extra reimbursement is available as these charges are not separately considered under the Plan. This means you could be responsible for these charges if you use an out-of-network provider.

Out-of-area services

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “inter-plan arrangements.” These inter-plan arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you access healthcare services outside the geographic area we serve, the claim for those services may be processed through one of these inter-plan arrangements. The inter-plan arrangements are described below.

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) don’t contract with the Host Blue. How we pay both kinds of providers:

A. BlueCard® Program. Under the BlueCard® Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers. When you receive covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services.
- The negotiated price that the Host Blue makes available to us.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non-BlueCard® Program) arrangements. With respect to one or more Host Blues, instead of using the BlueCard® Program, we may process your claims for covered healthcare services through Negotiated Arrangements for National Accounts. The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price under the BlueCard Program) made available to us by the Host Blue.

C. Special cases – value-based programs:

BlueCard® Program

We have included a factor for bulk distributions from Host Blues in your premium for value-based programs when applicable under this agreement.

Negotiated Arrangements

If we have entered into a negotiated arrangement with Host Blue to provide value-based programs to your members, we will follow the same procedures for value-based programs as noted above for the BlueCard Program.

D. Inter-Plan programs: Federal/state taxes/surcharges/fees. Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded plans. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed to you.

E. Nonparticipating providers outside the Blue Cross and Blue Shield of Alabama service area:

1. **Member liability calculation.** When covered healthcare services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's

nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. **Exceptions.** In certain situations, we may use other payment methods, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered healthcare services as set forth in this paragraph.

F. **Blue Cross Blue Shield Global® Core.** If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered healthcare services. Blue Cross Blue Shield Global® Core is not served by a Host Blue.

   If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global® Core service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

   - **Inpatient services.** In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services.
   - **Outpatient services.** Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.
   - **Submitting a Blue Cross Blue Shield Global® Core Claim.** When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global® Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the service center or online at bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Medical necessity and precertification

The Plan will only pay for care that is medically necessary and not investigational, as determined by us. "Investigational" is defined as any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when we make determinations about the investigational nature of a service or supply, we are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

In some cases (as described below), the Plan requires that you or your treating provider pre-certify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the Plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered.

In some cases, your provider will initiate the precertification process for you. You should be sure to check with your provider to confirm whether precertification has been obtained. It is your responsibility to ensure that you or your provider obtains precertification.

Inpatient hospital benefits
Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions.

For medical emergency services, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility.
- The baby is discharged and then readmitted.

For precertification call 1-800-248-2342 (toll-free).

IMPORTANT NOTE: Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the Plan.

Outpatient hospital benefits, physician benefits, other covered services
Precertification is required for the following outpatient hospital benefits, physician benefits and other covered services. You can find more information about the specific services that require precertification at AlabamaBlue.com/Precert. This list will be updated no more than twice a calendar year. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services.

The general categories or descriptions of outpatient hospital benefits, physician benefits and other covered services that require precertification at the time of the filing of this SPD include:

- Certain advanced imaging (such as, for example, MRA, MRI, CT, CTA and PET).
  For precertification, call 1-866-803-8002 (toll free).
- Intensive outpatient services and partial hospitalization.
  For precertification, call 1-800-548-9859 (toll-free).
- Certain select procedures (such as, for example, implantable bone conduction hearing aids, knee arthroplasty, lumbar spinal fusion, and surgery for obstructive sleep apnea).
  For precertification, call 1-800-248-2342 (toll-free).
- Certain reconstructive procedures (such as, for example, reduction mammoplasty, rhinoplasty, and surgery for varicose veins).
  For precertification, call 1-800-248-2342 (toll-free).
- Certain durable medical equipment (such as, for example, motorized/power wheelchair).
  For precertification, call 1-800-248-2342 (toll-free).
- Home health and hospice when services are rendered outside the state of Alabama.
  For precertification, call 1-800-821-7231 (toll free).

- Certain radiation therapy management services (such as, for example, proton beam therapy, cyberknife and stereotactic radiosurgery).
  For precertification, call 1-866-803-8002 (toll free).
- Certain genetic laboratory testing (such as, for example, breast cancer (BRCA) testing and genetic carrier screening).
  For precertification, call 1-866-803-8002 (toll free).
- ABA therapy.
  For precertification, call 1-877-563-9347 (toll free).

IMPORTANT NOTE: If precertification is not obtained, no benefits will be payable under the Plan for the services.

Provider-administered drugs
Precertification (also sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find a list of the provider-administered drugs that require precertification at AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. This list will be updated monthly.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office or home healthcare setting. Provider-administered drugs also include gene therapy and cellular immunotherapy. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

For precertification, call the Customer Service number on the back of your Member ID card.

IMPORTANT NOTE: If precertification is not obtained, no benefits will be payable under the Plan for the provider-administered drug.

Prescription drug benefits
Precertification (also sometimes referred to as prior authorization) is required for certain prescription drugs. You can find a list of the prescription drugs that require precertification at AlabamaBlue.com/StandardDrugList. This list will be updated quarterly.

For precertification, call the Customer Service number on the back of your Medical ID card.

IMPORTANT NOTE: If precertification is not obtained, no benefits will be payable under the Plan for the prescription drug.

Health benefits

Mental health disorders and substance abuse benefits
Except as described in Expanded psychiatric services (EPS) for mental health disorders and substance abuse later in this chapter, benefit levels for most mental health disorders and substance abuse are not separately stated. Please refer to the appropriate following sections that relate to the services or supplies you receive, such as *Inpatient hospital benefits*, *Outpatient hospital benefits*, etc.

Medical emergency or accidental injury when using out-of-network providers
If you receive out-of-network physician benefits (such as out-of-network laboratory services) for a medical emergency or accidental injury in the emergency room of a hospital, those services will also be paid at the applicable in-network coinsurance amounts for such benefits described in the matrices below, and subject to the in-network calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the requirements of the applicable federal law.

Non-emergency services when using an out-of-network provider
If you receive non-emergency services provided by and out-of-network provider at certain participating facilities, those services will be paid at the applicable in-network coinsurance and/or copayment amounts for such benefits described in the following sections, and subject to the in-network calendar year deductible, provided the out-of-network provider has not satisfied the applicable notice and consent requirements. The allowed amount for such non-emergency services performed by and

out-of-network provider at certain participating facilities will be determined in accordance with the requirements of the applicable federal law.

Inpatient hospital benefits

Precertification
Precertification is required for all hospital admissions except for medical emergency services, maternity admissions, and as required by federal law. You can find more information about this in the *Medical necessity and precertification* section of this chapter.

Service or supply	In-network Plan pays:	Out-of-network Plan pays:
First 365 days of care during each confinement in a general hospital or psychiatric specialty hospital (combined in-network and out-of-network)	100% of the allowed amount, no deductible, subject to a $200 per day copayment beginning with the 1st through the 5th day	80% of the allowed amount, subject to a $750 deductible per admission
Days of confinement in a general hospital or psychiatric specialty hospital extending beyond the 365-day benefit maximum	80% of the allowed amount, subject to the calendar year deductible Exception: Benefits for days exceeding 365 days for mental health and substance abuse admissions will be the same as the benefits shown above for the first 365 days	80% of the allowed amount, subject to the calendar year deductible Exception: Benefits for days exceeding 365 days for mental health and substance abuse admissions will be the same as the benefits shown above for the first 365 days

Inpatient hospital services in an out-of-network hospital
If you receive inpatient hospital services in an out-of-network hospital in the Alabama service area, no benefits are payable under the Plan unless services are to treat an accidental injury or medical emergency.

Inpatient hospital benefits consist of the following if provided during a hospital stay:

- Bed and board and general nursing care in a semiprivate room;
- Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them.
- Use of operating, delivery, recovery, and treatment rooms and the equipment in them.
- Administration of anesthetics by hospital employees and all necessary equipment and supplies.
- Casts, splints, surgical dressings, treatment and dressing trays.
- Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and X-rays.
- Physical therapy, hydrotherapy, radiation therapy, and chemotherapy.
- Oxygen and equipment to administer it.
- All drugs and medicines used by you if administered in the hospital.
- Regular nursery care and diaper service for a newborn baby while its mother has coverage.
- Blood transfusions administered by a hospital employee.

If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward any applicable maximum number of inpatient days.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the setting in which they were rendered. This means that we may, at times, reclassify an inpatient hospital admission as outpatient services. There may also be

times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

Group health plans and health insurance issuers offering group health insurance coverage 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 any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Outpatient hospital benefits

Precertification for certain outpatient hospital benefits
Precertification is required for certain outpatient hospital benefits. You can find more information about this in the *Medical necessity and precertification* section of this chapter.

Service or supply	In-network Plan pays:	Out-of-network Plan pays:
Outpatient surgery (including ambulatory surgical centers)	100% of the allowed amount, subject to a $200 outpatient facility copayment	80% of the allowed amount, subject to the calendar year deductible
Emergency room – medical emergency	100% of the allowed amount, subject to a $200 outpatient facility copayment	100% of the allowed amount, subject to a $200 outpatient facility copayment Mental health and substance abuse: 100% of the allowed amount, subject to a $200 outpatient facility copayment
Emergency room – accident	100% of the allowed amount, subject to a $200 outpatient facility copayment	100% of the allowed amount, subject to a $200 outpatient facility copayment
Outpatient diagnostic lab, X-ray, and pathology	100% of the allowed amount, no deductible or copayment	80% of the allowed amount, subject to the calendar year deductible
Outpatient dialysis, IV therapy, chemotherapy, and radiation therapy	100% of the allowed amount, no deductible or copayment	80% of the allowed amount, subject to the calendar year deductible
Services billed by the facility for an emergency room visit when the patient's condition does not meet the definition of a medical emergency (including any lab and X-ray exams and other diagnostic tests associated with the emergency room fee)	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible
Outpatient hospital services or supplies not listed above and not listed in the *Other covered services* section of this chapter	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible
Intensive outpatient services and partial hospitalization for mental health disorders and substance abuse	100% of the allowed amount, subject to a $40 copayment	80% of the allowed amount, subject to the calendar year deductible

IMPORTANT NOTE:
If you receive outpatient hospital services in an out-of-network hospital in the Alabama service area, no benefits are payable under the Plan unless services are to treat an accidental injury or medical emergency.

Outpatient hospital benefits include provider-administered drugs. You can find more information about provider-administered drugs in the *Medical necessity and precertification* section of this chapter.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the setting in which they were rendered. This means that we may, at times, reclassify an outpatient hospital service as an inpatient admission. There may also be times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

Physician benefits

Precertification for certain physician benefits
Precertification is required for certain physician benefits. You can find more information about this in the *Medical necessity and precertification* section of this chapter.

The following benefits apply only to the physician's charges for the services indicated. Claims for outpatient facility charges associated with any of these services will be processed under your outpatient hospital benefits and subject to any applicable outpatient facility copayments. Examples may include 1) laboratory testing performed in the physician's office, but sent to an outpatient hospital facility for processing; 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

Service or supply	In-network Plan pays:	Out-of-network Plan pays:
Office visits, consultations and psychotherapy	100% of the allowed amount, subject to a $40 copayment	50% of the allowed amount, subject to the calendar year deductible
Emergency room physician	100% of the allowed amount, subject to a $40 copayment	100% of the allowed amount, subject to a $40 copayment Mental health and substance abuse: 100% of the allowed amount, subject to a $40 copayment
Surgery and anesthesia for a covered service	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Second surgical opinion	100% of the allowed amount, subject to a $40 copayment	50% of the allowed amount, subject to the calendar year deductible
Maternity care	100% of the allowed amount, subject to the calendar year deductible	50% of the allowed amount, subject to the calendar year deductible
Applied behavioral analysis (ABA) therapy Limited to ages 0 – 18 for autism spectrum disorders	100% of the allowed amount, subject to a $40 copayment	80% of the allowed amount, subject to the calendar year deductible
Inpatient visits	100% of the allowed amount, subject to the calendar year deductible. Mental health and substance abuse: 100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible Mental health and substance abuse: 80% of the allowed amount, no deductible or copayment

Inpatient consultations by a specialty provider (limited to one consult per specialist per stay)	100% of allowed amount, subject to the calendar year deductible Mental health and substance abuse: 100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible Mental health and substance abuse: 80% of the allowed amount, no deductible or copayment
Diagnostic lab, X-rays and pathology	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible
Chemotherapy and radiation therapy	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible
Psychological testing	100% of the allowed amount, no deductible or copayment	50% of the allowed amount, subject to the calendar year deductible
Allergy testing and treatment	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures and heart catheterization.
- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.
- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.
- Physician benefits include provider-administered drugs. You can find more information about provider-administered drugs in the *Medical necessity and precertification* section of this chapter.

Physician preventive benefits

The benefits listed below apply only to the physician's charges for the services indicated. Claims for outpatient facility charges associated with any of these services will be processed under your outpatient hospital benefits and subject to any applicable outpatient facility copayments.

Examples may include 1) laboratory testing performed in the physician's office, but sent to an outpatient hospital facility for processing; 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

Service or supply	In-network Plan pays:	Out-of-network Plan pays:
Routine newborn exam (in hospital)	100% of the allowed amount, no deductible or copayment	Not covered
Routine well child care exams: • First 24 months: 9 visits • Ages 2 – 6: 1 visit per year	100% of the allowed amount, subject to a $40 copayment	Not covered
Routine immunizations See AlabamaBlue.com/immunizations for a listing of specific immunizations	100% of the allowed amount, no deductible or copayment	Not covered
Routine pap smear: One per calendar year	100% of the allowed amount, no deductible or copayment	Not covered

Routine screening mammogram: One exam for females ages 35 – 39 and one exam per calendar year for females ages 40 and over See the *Women's Health and Cancer Rights Act* section of the **Notices** chapter for additional information	100% of the allowed amount, no deductible or copayment	Not covered
Routine PSA / routine DRE (prostate specific antigen and digital rectal exam): One exam each calendar year for males ages 40 and over	100% of the allowed amount, no deductible or copayment	Not covered
Routine Human Papillomavirus (HPV) testing: One routine test every three calendar years for females ages 30 and over	100% of the allowed amount, no deductible or copayment	Not covered
Routine Hepatitis C screening: Limited to once per lifetime for members born between 1/1/1945 and 12/31/1965	100% of the allowed amount, no deductible or copayment	Not covered
Routine developmental screening: Limited to three services between the ages of 9 and 30 months	100% of the allowed amount, no deductible or copayment	Not covered
Routine Chlamydia screening: One exam per calendar year for females ages 15 – 24	100% of the allowed amount, no deductible or copayment	Not covered
Routine office visits: One office visit per calendar year for members eligible for routine pap smear, routine mammogram, or routine PSA	100% of the allowed amount, subject to a $40 copayment	Not covered
Colorectal cancer screening – ages 45 and over: • Fecal occult blood test (FOBT) once per calendar year. • Flexible sigmoidoscopy once every three calendar years. • Double-contrast barium enema once every five calendar years. • Colonoscopy once every 10 calendar years. • FIT-DNA (Cologuard) for ages 45 – 99, once every three calendar years.	100% of the allowed amount, no deductible or copayment. Note: Claims for facility charges will be processed as outpatient hospital benefits and subject to any applicable outpatient copayments.	Not covered

Some immunizations may be covered in-network not only when provided in an in-network physician's office, but also when provided by an in-network pharmacy that participates in the Pharmacy Vaccine Network. Pharmacy Vaccine Network pharmacies have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to provide and administer certain immunizations.

1. Go to AlabamaBlue.com/PrimeParticipatingVaccinePharmacyLocator.
2. Enter a search location by using the Zip code or city and state for the area you would like to search.

3. Click the Search button to find a pharmacy in the Vaccine Network.

A list of the eligible vaccines these pharmacies may provide can be found at AlabamaBlue.com/VaccineNetworkDrugList.

Expanded Psychiatric Services (EPS) for mental health disorders and substance abuse
You may receive mental health disorder and substance abuse benefits under the Plan through either an EPS provider or a non-EPS provider. If you choose to use a non-EPS provider, please refer to the appropriate sub-sections throughout this *Health benefits* section that relate to the services or supplies you receive to determine the benefits available. Example: If you see a physician for services related to mental health disorders or substance abuse, refer to the *Physicians benefits* section and locate the service or supply to determine the applicable benefit level.

You are encouraged to maximize your benefits and have your care for mental health disorders or substance abuse coordinated by an EPS provider. EPS providers participate in a program called Expanded Psychiatric Service (EPS). The EPS program provides members with a broad range of services for treatment of mental health disorders without any deductibles or copayments when care is coordinated by an EPS provider. Providers who participate in the EPS network are available throughout Alabama and in a few locations in states bordering Alabama. A list of EPS providers can be found in the Expanded Psychiatric Services Network directory. To find an EPS provider, call Customer Service or search using the "Find a Doctor" tool at AlabamaBlue.com/FindADoctor.

1. In the search box, you can select the category you would like to search under (behavioral health provider, doctor, pharmacy, etc.) or keep on "All Categories" to search all. Type in the provider's name to search or leave blank to see all results.
2. In the "Network or Plan" section, use the drop down menu to select a specific provider network (such as "Expanded Psychiatric Services").

Search tip: If your search returns zero results, try expanding the number in the "Distance" drop down.

Service	Plan pays:
Inpatient facility	100% of the allowed amount, no deductible or copayment
Physician	
Therapy expenses	
Outpatient visits	
Individual, group, and family therapy or counseling	
Psychological and laboratory testing	
Services by professional staff members such as psychologists and social workers in mental health and chemical dependency	
ABA Therapy	

The following services or supplies are not included under the EPS program:
- Speech therapy.
- Diagnosis or treatment of mental retardation.
- Rehabilitation of a temporary or permanent disability or for hearing or vision impairment.
- Treatment for chronic pain or solely for obesity.
- Services related to narcotic maintenance therapy such as methadone maintenance therapy.
- Services related to nicotine addiction.
- Sex therapy programs or treatment for sex offenders.
- Prescription drugs.
- Residential psychiatric facilities.

IMPORTANT NOTE: See the *Health benefit exclusions* section of this chapter for services or supplies that are not included when using non-EPS providers.

Other covered services

Precertification is required for certain other covered services
Precertification is required for certain other covered services. You can find more information about this in the *Medical necessity and precertification* section of this chapter.

Service or supply	In-network Plan pays:	Out-of-network Plan pays:
Accident-related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible
Ambulance services	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible
Chiropractic services Limited to 15 visits per person per calendar year	80% of the allowed amount, subject to the calendar year deductible	Non-participating chiropractors in Alabama: 50% of the allowed amount, subject to the calendar year deductible Non-participating chiropractors outside Alabama: 80% of the allowed amount, subject to the calendar year deductible
Dialysis services at a renal dialysis facility	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible
Durable medical equipment (DME) and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, and splints Note: For DME the allowed amount will generally be the smaller of the rental or purchase price	80% of the allowed amount, subject to the calendar year deductible	Non-preferred DME supplier in Alabama: 50% of the allowed amount, subject to the calendar year deductible Non-preferred DME supplier outside Alabama: 80% of the allowed amount, subject to the calendar year deductible
Eyeglasses or contact lenses: One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible

Home health and hospice care: In-network home healthcare benefits consist of intermittent home nursing visits and home phototherapy for newborns ordered by your attending physician In-network hospice benefits consist of physician home visits medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management provided to a member certified by his physician to have less than six months to live	100% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible **Note:** Not covered in Alabama
Home infusion benefits include coverage of certain provider-administered drugs ordered by your attending physician and administered by a home infusion service provider in the home or in an infusion site associated with the home infusion service provider. In-network benefits include coverage of the provider-administered drug and drug infusion related administration services. See *Provider-administered drugs* in the *Medical necessity and precertification* section of this chapter for precertification requirements of these drugs.	100% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible **Note:** Not covered in Alabama
Medical nutrition therapy services for adults and children, 6 hours each calendar year	100% of the allowed amount, subject to a $40 copayment	50% of the allowed amount, subject to the calendar year deductible
Habilitative occupational, physical and speech therapy: Limited to a combined maximum of 30 visits per member per calendar year (combined in-network and out-of-network)	80% of the allowed amount, subject to the calendar year deductible	**In Alabama:** 50% of the allowed amount, subject to the calendar year deductible **Outside Alabama:** 80% of the allowed amount, subject to the calendar year deductible
Rehabilitative occupational, physical and speech therapy: Limited to a combined maximum of 30 visits per member per calendar year (combined in-network and out-of-network)	80% of the allowed amount, subject to the calendar year deductible	**In Alabama:** 50% of the allowed amount, subject to the calendar year deductible **Outside Alabama:** 80% of the allowed amount, subject to the calendar year deductible
Occupational, physical and speech therapy services with autism spectrum disorder diagnosis ages 0 – 18	80% of the allowed amount, subject to the calendar year deductible	**In Alabama:** 50% of the allowed amount, subject to the calendar year deductible **Outside Alabama:** 80% of the allowed amount, subject to the calendar year deductible

Prescription drug benefits

Precertification is required for certain prescription drugs
Precertification (sometimes referred to as prior authorization) is required for certain prescription drugs. You can find more information about this in the *Medical necessity and precertification* section of this chapter.

Service or supply	In-network Plan pays:	Out-of-network Plan pays:
Prescription drug card The pharmacy network for the Plan is the **Prime Participating Pharmacy Network**. For participating retails pharmacies, visit AlabamaBlue.com/PrimeParticipating/PharmacyLocator Some drugs may require precertification Prescription drugs can be dispensed for up to a 30-day supply Prescription drugs – up to a 90-day supply may be purchased but a copayment applies for each 30-day supply Some copayments combined for diabetic supplies Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for specialty drugs is the **Pharmacy Select Network**. Go to AlabamaBlue.com/SelfAdministeredSpecialtyDrugList for a list of these specialty drugs View the **Standard Prescription Drug** list that applies to the Plan at AlabamaBlue.com/StandardDrugList Some immunizations may be received from in-network pharmacy that participates in the Pharmacy Vaccine Network. • A list of eligible vaccines these pharmacies may provide can be found at AlabamaBlue.com/VaccineNetworkDrug List	100% of the allowed amount, subject to the following copayments: • **Tier 1 drugs**: $15 copayment • **Tier 2 drugs**: $40 copayment • **Tier 3 drugs**: $55 copayment **Generic drugs are mandatory when available.** Generic drugs may be classified at any Tier. A generic drug is one that the FDA has approved under an Abbreviated New Drug Application (ANDA) and no New Drug Application (NDA) is on file. A generic drug is also one that is manufactured by more than one manufacturer and is designated as a multi-source product by the major drug database providers, Medispan and First DataBank. **Covered insulin products** $99 maximum cost share per 30-day supply	Not covered

Prescription drug benefits are subject to the following terms and conditions:

- To be eligible for benefits, drugs must be FDA-approved legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, “Caution: Federal law prohibits dispensing without a prescription.”
- Drugs are classified in tiers generally by their cost to the Plan with Tier 1 drugs having the lowest cost to the Plan and Tier 3 having the highest cost to the Plan. To determine the Tier in which a drug is classified by your plan, log into *my*BlueCross at AlabamaBlue.com. Once there, you can search for your drug by clicking the “Find Drug Pricing” link located in the *Manage My Prescriptions* section of the website. The Tier drug classifications are updated periodically.
- Prescription drug coverage is subject to *Drug Coverage Guidelines* developed and modified over time based upon daily or monthly limits as recommended by the Food and Drug Administration, the manufacturer of the drug, and/or peer-reviewed medical literature. These guidelines can be found in the pharmacy section of our website. Even though your physician has written a prescription for a drug, the drug may not be covered under the plan, or clinical edit(s) may apply (i.e., prior authorization, step therapy, quantity limitation) in accordance with the guidelines. A drug may not be covered under the Plan because, for example, there are safety and/or efficacy concerns or there

are over-the-counter equivalent drugs available. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. You may call the Customer Service number on the back of your Member ID card for more information.

- Prescription drug benefits are provided only if dispensed by an in-network pharmacy. Except for certain specialty drugs, in-network pharmacies are pharmacies that have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense prescription drugs under the plan. For certain specialty drugs, in-network pharmacies must have a contract with Blue Cross and Blue Shield of Alabama or its pharmacy benefit manager(s) to dispense these specialty drugs.
- Specialty drugs are high-cost drugs that may be used to treat certain complex and rare medical conditions and are often self-injected or self-administered. Specialty drugs often grow out of biotech research and may require refrigeration or special handling.
- Compound drugs are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded drugs may be subject to additional coverage criteria and utilization management edits. Compounds are covered only when medically necessary. Compound drugs are always classified as Tier 3 drugs.

IMPORTANT NOTE:
Just because a drug is classified by the Plan as Tier 1 or any other classification on our website does not mean the drug is safe or effective for you. Only you and your prescribing physician can make that determination.

- Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used (e.g., 23 days into a 30-day supply). Your pharmacist may be able to synchronize the refill date for your prescriptions. Ask your pharmacist if prescription drug medication synchronization is available for drugs.
- Insulin, needles, and syringes purchased on the same day will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day will have one copayment. Otherwise, each has a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan. Glucose monitors always have a separate copayment.
- If your drug is not covered and you think it should be, you may ask us to make an exception to the drug coverage rules. Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception.

Provider-administered drug benefits

Precertification is required for certain provider-administered drugs
Precertification (sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find more information about this in the *Medical necessity and precertification* section of this chapter.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician’s office or other home healthcare setting. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

Provider-administered drugs also include gene therapy and cellular immunotherapy. Gene therapy is generally a therapy designed to introduce genetic material into cells to compensate for abnormal genes or to make a beneficial protein. Cellular immunotherapy is generally the artificial stimulation of the immune system to treat cancer, such as cytokines, cancer vaccines oncolytic virus therapy, T-cell therapy and some monoclonal antibodies.

Provider-administered drug coverage is subject to *Drug Coverage Guidelines* and medical necessity policies found in the pharmacy section of our website. A drug may not be covered under the Plan because, for example, if there are safety and/or efficacy concerns. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. The guidelines in some instances also require the drug be administered by a provider and/or facility approved by the drug manufacturer.

Additional benefit information

Individual case management
If you suffer from catastrophic, long-term or chronic illness or injury, a Blue Cross Registered Nurse may work with you, your physician, and other healthcare professionals to design a benefit plan to best meet your healthcare needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to Blue Cross, you, and your physician. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through individual case management are subject to your Plan benefit maximums. If you think you may benefit from individual case management, please call our Health Management Department at 1-205-733-7067 or 1-800-821-7231 (toll-free).

Chronic condition management
You may also qualify to participate in the chronic condition management program. The chronic condition management program is available for members with heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD), asthma, and other specialized conditions. This program offers personalized care designed to meet your lifestyle and health concerns. Our staff of healthcare professionals will help you cope with your illness and serve as a source of information and education. Participation in the program is completely voluntary. If you would like to enroll in the program or obtain more information, call 1-888-841-5741 (Monday – Friday, 8 a.m. to 4:45 p.m. CST), or e-mail membermanagement@bcbsal.org.

Baby Yourself program
Baby Yourself offers individual care by a registered nurse. Please call our nurses at 1-800-222-4379 (or 1-205-733-7065 in Birmingham) or visit AlabamaBlue.com/BabyYourself as soon as you find out you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant.

If you fall into one of the following risk categories, please tell your doctor and your Baby Yourself nurse: age 35 or older; high blood pressure; diabetes; history of previous premature births; multiple births (twins, triplets, etc.).

Organ and bone marrow transplants
The organs for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney; and (6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve a facility for transplant services it is limited to the specific types of transplants stated. Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma.

Transplant benefits for cadaveric donor organ costs are limited to search, removal, storage and the transporting of the organ and removal team.

Transplant benefits for living donor expenses are limited to:
- Solid organs: testing for related and unrelated donors as pre-approved by us.
- Bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrow registry.
- Pre-diagnostic testing expenses of the actual donor for the approved transplant.
- Hospital and surgical expenses for removal of the donor organ, and all such services provided to the donor during the admission.
- Transportation of the donated organ
- Post-operative hospital, medical, laboratory and other services for the donor related to the organ transplant limited to up to 90 days of follow-up care after date of donation.

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the Plan applicable to the member, such as deductibles, copays, coinsurance, and other Plan limitations. For example, if the member's

coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

There are no transplant benefits for: (1) any investigational/experimental artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) donor costs if the recipient is not covered by this plan; (7) recipient or donor lodging, food, or transportation costs, unless otherwise specifically stated in the plan; (8) a condition or disease for which a transplant is considered investigational; (9) transplants (excluding kidney) performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

Tissue, cell and any other transplants not listed above are not included in this organ and bone marrow transplant benefit but may be covered under other applicable provisions of the Plan when determined to be medically necessary and not investigational. These transplants include but are not limited to: heart valves, tendon, ligaments, meniscus, cornea, cartilage, skin, bone, veins, etc.

Air medical transport service(s)
If a member is hospitalized while traveling more than 150 miles from home (calculated as a straight-line distance, not road miles) air medical transportation is available to transport the member to a network hospital of their choice near their home. Ground ambulance transportation is provided from the hospital to the aircraft and then from the aircraft to the receiving hospital.

Air medical transportation is also available in some cases when a member needs specialized hospital services in a hospital located more than 150 miles from their primary residence so long as the hospital is located within the country of residence (United States or Canada only), the member is unable to travel by commercial means without a medical escort, and the transport is approved by us. This includes transport of transplant recipients.

There are no deductibles, copayments, or coinsurance applicable and there are no claim forms to file for this service. Members call a toll free hotline 1-877-872-8624 (available 24 hours a day, 7 days a week) to request air transport services. There are no restrictions on the number of travel days within the United States but services are available only twice per calendar year per member and are not available to members travelling outside the United States for more than 90 consecutive days. Services are also not available for (1) any location where the U.S. State Department has issued travel restrictions or declared to be high risk areas; (2) any member with tuberculosis or other chronic airborne pathogens; (3) in most instances, a member beyond the second trimester of pregnancy; (4) members with simple injuries or mild illnesses which do not require hospitalization.

Women’s Health and Cancer Rights Act Information
A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema. Benefits for this treatment will be subject to the same calendar year deductible and coinsurance provisions that apply for other medical and surgical benefits.

Coordination of Benefits (COB)

COB is a provision designed to help manage the cost of healthcare by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary. A primary plan is one whose benefits for a person’s healthcare coverage must be determined first without taking the existence of any other plan into consideration. A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

Order of benefit determination
Which plan is primary is decided by the following first rule that applies:

Noncompliant plan: If the other plan is a “noncompliant” plan – defined as a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this Plan – then the other plan shall be primary and this Plan shall be secondary unless the COB terms of both plans provide that this Plan is primary.

Employee/dependent: The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the group, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

Dependent child – parents not separated or divorced: If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married), the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

Dependent child – separated or divorced parents: If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
   - **a.** First, the plan of the custodial parent;
   - **b.** Second, the plan covering the custodial parent's spouse;
   - **c.** Third, the plan covering the non-custodial parent; and,
   - **d.** Last, the plan covering the non-custodial parent's spouse.
2. If a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

   If the court-ordered parent has no healthcare coverage for the dependent child, benefits will be determined in the following order:
   - **a.** first, the plan of the spouse of the court-ordered parent;
   - **b.** second, the plan of the non-court-ordered parent; and,
   - **c.** third, the plan of the spouse of the non-court-ordered parent.

   If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of *Dependent child – parents not separated or divorced* (the "birthday rule") above shall determine the order of benefits.

   If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.
3. 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 the "birthday rule" as if those individuals were parents of the child.

Active employee or retired or laid-off employee

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
2. 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.
3. This rule does not apply if the rule in the previous *Employee/dependent* section can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

COBRA or State Continuation Coverage:

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to 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 plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the previous *Employee/dependent* section can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer's plan (the "COBRA plan") and is also covered as a dependent under an active spouse's plan, the COBRA plan will be primary and the spouse's active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse's plan (the "COBRA plan") and is also covered as a dependent under a new spouse's plan, the COBRA plan will be primary and the new spouse's plan will be secondary.

Longer/shorter length of coverage: If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

Equal division: If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Determination of amount of payment

1. If this Plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this Plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this Plan is a secondary plan on a claim, should it wish to coordinate benefits (that is, pay benefits as a secondary plan rather than as a primary plan with respect to that claim), this Plan shall calculate the benefits it would have paid on the claim in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. When paying secondary, this Plan may 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 do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage. In some instances, when this Plan is a secondary plan, it may be more cost effective for the Plan to pay on a claim as if it were the primary plan. If the Plan elects to pay a claim as if it were primary, it shall calculate and pay benefits as if no other coverage were involved.

Coordination of Benefits (COB) terms

Allowable expense: Except as set forth below or where a statute requires a different definition, the term "allowable expense" means any health care expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term "allowable expense" does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this Plan. For example, if this Plan does not provide benefits for mental health disorders and substance abuse, dental services and supplies, vision care, prescriptions drugs, or hearing aids, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term "allowable expense" does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan's provisions

concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

Birthday: The term “birthday” refers only to month and day in a calendar year and does not include the year in which the individual is born.

Custodial parent: The term “custodial parent” means:

- A parent awarded custody of a child by a court decree; or,
- In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

Group-type contract: The term “group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. The term does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

Hospital indemnity benefits: The term “hospital indemnity benefits” means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Noncompliant plan: The term “noncompliant plan” means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are “excess” or “always secondary.”

Plan: The term “plan” includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term “plan” does not include non-group or individual health or medical reimbursement insurance contracts. The term “plan” also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Primary plan: The term “primary plan” means a plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or,
- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary plan: The term “secondary plan” means a plan that is not a primary plan.

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. We may get the facts we need 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. We are not required to tell or get the consent of any person to do this. Each person claiming benefits under this Plan must give us any facts we need to apply these COB rules and to determine benefits payable as a result of these rules.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, we 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. We 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 us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons it has paid to 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.

Special rules for coordination with Medicare
Except where otherwise required by federal law, the Plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this Plan is secondary to Medicare under federal law, this Plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.

Subrogation

Right of subrogation
If we pay or provide any benefits for you under this Plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

Right of reimbursement
Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we have paid Plan benefits. This means that you promise to repay us from any money you recover the amount we have paid or provided in Plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us. And, if you are paid by any person or company besides us, including the person who injured you, that person’s insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides Plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to recovery
You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce this plan’s rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney’s fees charged to you by your attorney for obtaining the recovery. If you do not give us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

You further agree not to allow our reimbursement and subrogation rights under this Plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the Plan.

Health benefit exclusions

In addition to other exclusions set forth in this chapter, we **will not** provide benefits under any portion of this chapter for the following:

- Services or expenses for **acupuncture**, biofeedback, behavioral modification and other forms of self-care or self-help training.
- **Anesthesia** services or supplies or both by local infiltration.
- Services, care, treatment, or supplies furnished by a provider that is not recognized by us as an **approved provider** for the type of service or supply being furnished. For example, we reserve the right not to pay for some or all services or supplies furnished by certain persons who are not medical doctors (M.D.s), even if the services or supplies are within the scope of the provider's license. Call Customer Service if you have any question as to whether your provider is recognized as an approved provider for the services or supplies that you intend to receive.
- Services or expenses for or related to **Assisted Reproductive Technology (ART)**. ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.
- Services or expenses of a hospital stay, except one for an emergency, unless we **certify** it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 48 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.
- Services or expenses for which a **claim** is not properly submitted to Blue Cross.
- Services or expenses for a **claim we have not received within 24 months** after services were rendered or expenses incurred.
- Services or expenses for personal hygiene, **comfort or convenience** items such as: air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.
- Services or expenses for sanitarium care, **convalescent care**, or rest care, including care in a nursing home.
- Services or expenses for cosmetic surgery. **Cosmetic surgery** is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.
  - You must contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.
  - Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.
- Services or expenses for treatment of injury sustained in the commission of a **crime** (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.

- Services or expenses for **custodial care**. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.
- **Dental** implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.
- Except as may be otherwise expressly covered in this chapter, **dietary** instructions.
- Services, care, or treatment you receive after the **ending date of your coverage.** This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this Plan is in effect.
- **Eyeglasses** or contact lenses or related examinations or fittings, except under the limited circumstances set forth in the *Other covered services* section of this chapter.

  Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.
- Services or expenses in any **federal hospital or facility** except as required by federal law.
- Services or expenses for routine **foot care** such as removal of corns or calluses or the trimming of nails (except mycotic nails).
- Unless otherwise required by applicable law, services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other **governmental** agency that provides or pays for care, through insurance or any other means.
- **Hearing aids** or examinations or fittings for them.
- **Investigational** treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including services that are part of a clinical trial.
- Services or expenses that you are not **legally obligated to pay**, or for which no charge would be made if you had no health coverage.
- Services or expenses for treatment which does not require a **licensed provider**, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency, or duration.
- Services or expenses we determine are not **medically necessary**.
- Services or supplies to the extent that a member is, or would be, entitled to reimbursement under **Medicare**, regardless of whether the member properly and timely applied for, or submitted claims to Medicare, except as otherwise required by federal law.
- Services or expenses for or related to the diagnosis or treatment of **mental retardation**.
- Services or expenses of any kind for **nicotine addiction**.
- Services, care or treatment you receive during any period of time with respect to which we have **not been paid for your coverage** and that **nonpayment** results in termination.
- Services or expenses rendered by out-of-network Certified Registered **Nurse Practitioners** (CRNP) or out-of-network Certified **Nurse Midwives** (CNM).
- Unless otherwise expressly covered under the *Physician preventive benefits* section of this chapter, services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion includes bariatric surgery and gastric restrictive procedures and any complications arising from bariatric surgery and gastric restrictive procedures (This exclusion does not apply to cardiac or pulmonary rehabilitation, diabetes self- management programs or Plan approved programs for pediatric obesity).

- Services or expenses provided by an **out-of-network provider** for any benefits under this Plan, unless otherwise specifically stated in the Plan.
- Hot and cold **packs**, including circulating devices and pumps.
- **Private duty nursing**.
- Services or expenses for **recreational** or educational therapy (except for plan-approved ABA Therapy, diabetic self-management programs, pulmonary rehabilitation programs, or Phase 1 or 2 cardiac rehabilitation programs).
- Hospital admissions in whole or in part when the patient primarily receives services to **rehabilitate** such as physical therapy, speech therapy, or occupational therapy unless the admission is determined to be medically necessary for acute inpatient rehabilitation.
- Services or expenses for learning or vocational **rehabilitation**.
- Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical therapist.
- **Replacement or upgrade** of existing properly functioning durable medical equipment (including prosthetics), even if the warranty has expired.
- **Residential treatment.**
- Services or supplies furnished by a facility that is solely classified as a **residential treatment center**. This does not exclude covered substance abuse services or supplies furnished by a general hospital, psychiatric specialty hospital or substance abuse facility.
- **Room and board** for hospital admissions in whole or in part when the patient primarily receives services that could have been provided on an outpatient basis based upon the patient's condition and the services provided.
- **Routine physical examinations** except for the services described in the *Physician preventive benefits* section of this chapter. **Routine well child care** and routine immunizations except for the services described in *Physician preventive benefits*.
- Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition).
- Services or expenses for, or related to **sex therapy** programs or treatment for **sex offenders**. Services or supplies furnished by a **skilled nursing facility**.
- Services, **supplies**, equipment, accessories or other items which can be purchased at retail establishments or otherwise over-the-counter without a doctor's prescription that are not otherwise covered services under another section of this chapter, including but not limited to:
  - Hot and cold packs;
  - Standard batteries used to power medical or durable medical equipment;
  - Solutions used to clean or prepare skin or minor wounds including alcohol solution or wipes, povidone-iodine solution or wipes, hydrogen peroxide, and adhesive remover;
  - Standard dressing supplies and bandages used to protect minor wounds such as band aids, 4 x 4 gauze pads, tape, compression bandages, eye patches;
  - Elimination and incontinence supplies such as urinals, diapers, and bed pans; and
  - Blood pressure cuffs, sphygmometers, stethoscopes and thermometers.
- Services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are Plan benefits. For example, braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw or because of injury of natural teeth. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under *Other covered services*.

- Dental treatment for or related to Phase II **temporomandibular joint (TMJ) disorders** according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.
- Services, supplies, implantable devices, equipment and accessories billed by any out-of-network **third party vendor** that are used in surgery or any operative setting. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.
- **Transcutaneous Electrical Nerve Stimulation (TENS)** equipment and all related supplies including TENS units, Conductive Garments, application of electrodes, leads, electrodes, batteries and skin preparation solutions.
- Services or expenses for or related to organ, tissue or cell **transplants** except specifically as allowed by this plan.
- **Travel**, even if prescribed by your physician (not including ambulance services otherwise covered under the plan).
- Services or expenses for an accident or illness resulting from active participation in **war**, or any act of war, declared or undeclared, or from active participation in riot or civil commotion.
- Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation is available in whole or in part under the provisions of any **Workers' Compensation** or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the group. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your group has insurance coverage for benefits under the law.

Claims and appeals

Remember that you may always call Customer Service for help if you have a question or problem that you would like us to handle without an appeal. Call the phone number on the back of your Member ID card to reach Customer Service

Claims for benefits under the Plan can be post-service, pre-service, or concurrent. This section of the chapter explains how we process these different types of claims and how you can appeal a partial or complete denial of a claim.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of this chapter. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can obtain the form by calling Customer Service. You can also go to AlabamaBlue.com and ask us to mail you a copy of the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of the chapter.

For urgent pre-service claims, we will presume that your provider is your authorized representative unless you tell us otherwise in writing.

Post-service claims

What constitutes a claim: For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), we must receive a properly completed and filed claim from you or your provider.

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call Customer Service and ask for a claim form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858. Claims must be submitted and received by us within 24 months after the service takes place to be eligible for benefits.

If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

Processing of claims: Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. If we need additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim is filed. If it is necessary for us to ask for additional information, we will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

Pre-service claims

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the Plan.

In order to file a pre-service claim, you or your provider must call our Health Management Department at 1-205-988-2245 or 1-800-248-2342 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing

Written pre-service claims should be sent to us at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD). CURP is a program implemented by us and in-network hospitals in the Alabama service area to simplify the administration of preadmission certifications and concurrent utilization reviews. If your Plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you. For home healthcare and hospice benefits (if covered by your plan), see the previous sections of this chapter for instructions on how to pre-certify treatment.

If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Our notification may be oral, unless you ask for it in writing. We will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters, and (2), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent pre-service claims: We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing within three days. If we do not receive the

information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing the information to us.

Non-urgent pre-service claims: If your claim is not urgent, we will notify you of our decision within 15 days. If we need more information, we will let you know before the 15-day period expires. We will tell you what further information we need. You will then have 90 days to provide this information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time. We will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

Courtesy pre-determinations: For some procedures we encourage, but do not require, you to contact us before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask us to determine beforehand whether the procedure is cosmetic or reconstructive. We call this type of review a courtesy pre-determination. If you ask for a courtesy pre- determination, we will do our best to provide you with a timely response. If we decide that we cannot provide you with a courtesy pre-determination (for example, we cannot get the information we need to make an informed decision), we will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When we process requests for courtesy pre-determinations, we are not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call Customer Service.

Concurrent care determinations

Determinations by us to limit or reduce previously approved care: If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by you to extend previously approved care: If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 1-205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy call 1-205-220-7202.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, we will give you our decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post- service time frames discussed above.

Your right to information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a healthcare professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Appeals

If you are dissatisfied with our adverse benefit determination of a claim, you may file an appeal with us. You cannot file a claim for benefits under the Plan in federal or state court (or in arbitration if provided by your plan) unless you exhaust these administrative remedies.

The rules in this section of this chapter allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

- Any determination we make with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- Our denial of a pre-service claim; or,
- An adverse concurrent care determination (for example, we deny your request to extend previously approved care); or
- Your group's denial of your or your dependents' initial eligibility for coverage under the Plan or your group's retroactive rescission of your or your dependents' coverage for fraud or intentional misrepresentation of a material fact.

In all cases other than determinations by us to limit or reduce previously approved care and determinations by your group regarding initial eligibility or retroactive rescission, you have 180 days following our adverse benefit determination within which to submit an appeal.

How to appeal your group's adverse eligibility and rescission determinations: If you wish to file an appeal on your group's adverse determination relating to initial eligibility for coverage or retroactive rescission of coverage, you should check with your group regarding your group's appeal procedures.

How to appeal post-service adverse benefit determinations: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call Customer Service. You may also go to AlabamaBlue.com. Once there, you may request a copy of the form.

If you choose not to use our appeal form, you may send us a letter. Your letter must contain at least the following information:

- The patient's name.
- The patient's contract number.
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available). (The best way to satisfy this requirement is to include a copy of your claims report with your appeal.)
- A statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield of Alabama
Attention: Customer Service Department – Appeals
P.O. Box 12185
Birmingham, Alabama 35202-2185

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

How to appeal pre-service adverse benefit determinations: You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 1-205-988-2245 or 1-800-248-2342 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy call 1-205-220-7202.

If in writing, you should send your letter to the appropriate address listed below:

- For inpatient hospital care and admissions:

  Blue Cross and Blue Shield of Alabama
  Attention: Health Management Department – Appeals
  P.O. Box 2504
  Birmingham, Alabama 35201-2504

- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy:
  Blue Cross and Blue Shield of Alabama
  Attention: Health Management Department – Appeals
  P.O. Box 362025
  Birmingham, Alabama 35236

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

Conduct of the appeal: We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are medically necessary), we will consult a healthcare professional who has appropriate expertise. If we consulted a healthcare professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases, we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

Time limits for our consideration of your appeal: If your appeal arises from our denial of a post- service claim, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a pre-service claim, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. If your pre-service claim is not urgent, we will give you a response within 30 days.

If your appeal arises out of a determination by us to limit or reduce a hospital stay or course of treatment that we previously approved for a period of time or number of treatments, (see *Concurrent care determinations* above), we will make a decision on your appeal as soon as possible, but in any event before we impose the limit or reduction.

If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see *Concurrent care determinations* above), we will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

If you are dissatisfied after exhausting your mandatory Plan administrative remedies: If you have filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- You may ask Customer Service for further help.
- You may file a voluntary appeal (discussed below).
- You may file a claim for external review in certain surprise billing situations (discussed below).
- You may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your Plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination,

you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

Surprise billing external review
You may file a request with us for an independent, external review when an adverse benefit determination involves an item or service within the scope of the surprise billing and cost-sharing protections of the No Surprises Act. This includes items and services for out-of-network emergency services, nonemergency services performed by nonparticipating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. You must request this external review within four (4) months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address: Blue Cross and Blue Shield of Alabama, Attention: Customer Service Department – Appeals, P.O. Box 10744, Birmingham, AL 35202- 0744. If you request an external review, an independent organization will review our decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give us copies of this additional information to give us an opportunity to reconsider our denial. Both of us will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both of us.

COBRA

For additional information about your COBRA rights and options, see the **Plan Administration and ERISA Rights** chapter of this SPD.

You can enroll in COBRA coverage online by going to uhcservices.com and clicking on “Register.” If you enroll and pay online, you do not have to return the paper form you will receive in the mail.

To return the completed form by mail, send to:

UnitedHealthcare Customer Care Center
Attn: Benefit Services
PO Box 740221
Atlanta, GA 30374-0221

You can also enroll by calling UnitedHealthcare Benefits Services at 1-866-747-0048.

General information

Delegation of discretionary authority to Blue Cross
The group has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of benefits and/or administrative services under the Plan.

Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the Plan (including, when applicable, arbitration) and thereafter to judicial review to determine whether our determination was arbitrary or capricious (in the case of claims covered by Section 502(a) of ERISA) or correct using the standard of review set forth in any applicable arbitration provisions of this chapter.

Notice of determination
We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so.

Unless otherwise specified in this chapter, if you are required to provide notice to us, you should do so in writing, including your full name and contract number, and mail the notice to us at 450 Riverchase Parkway East, P.O. Box 995, Birmingham, Alabama 35298-0001.

Correcting payments
While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will be reflected in your claims report.

Responsibility for providers
We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we are not responsible. We need not do anything to enable them to treat you.

Misrepresentation
If you commit fraud or make any intentional material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the Plan never took effect, and we need not refund any payment for any member.

Governing law
The law governing the Plan and all rights and obligations related to the Plan shall be ERISA, to the extent applicable. To the extent ERISA is not applicable, the Plan and all rights and obligations related to the Plan shall be governed by, and construed in accordance with, the laws of the state of Alabama, without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the Plan.

Termination of benefits and termination of the Plan
Our obligation to provide or administer benefits under the Plan may be terminated at any time by either the group or us by giving written notice to the other as provided for in the contract. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If the group fails to pay us the amounts due under the contract within the time period specified therein, our obligation to provide or administer benefits under the Plan will terminate automatically and without notice to you or the group as of the date due for payment. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

Subject to any conditions or restrictions in our contract with the group, the group may terminate the Plan at any time through action by its authorized officers. In the event of termination of the plan, all benefit payments by us will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by the group or us. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If for any reason our services are terminated under the contract, you will cease to receive any benefits by us for any and all claims incurred after the effective date of termination. In some cases, this may mean retroactive cancellation by us of your Plan benefits. This is true for active contract holders, retirees, COBRA beneficiaries and dependents of either. Any fiduciary obligation to notify you of our termination belongs to the group, not to us.

Changes in the Plan
By giving a 30-day notice to the group, we may amend any and all provisions of the Plan or the amount of fees that you or your group must pay for coverage under the Plan (If the change is a material modification in any of the terms of the Plan that would affect the content of the Summary of Benefits and Coverage for the Plan that is not reflected in the most recently provided Summary of Benefits and Coverage, and the change occurs other than in connection with a renewal or reissuance of coverage, the Plan will give you written notice at least 60 days before the effective date of the

change). The fiduciary obligation to notify you of these changes belongs to the group, not us. The Plan amendment will be effective whether or not the group has notified you of the amendment. Payment of premiums by the group after the effective date of the amendment will constitute acceptance by you and the group of the changes.

Except as otherwise provided in the contract, no representative or employee of Blue Cross is authorized to amend or vary the terms and conditions of the Plan or to make any agreement or promise not specifically contained in the Plan documents or to waive any provision of the Plan documents. This means, in part, that no representative, employee, or agent of Blue Cross may make any changes to the Plan over the telephone or verbally.

No assignment

As discussed in more detail in the *Claims and appeals* section of this chapter, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call Customer Service and ask for a claim form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network provider (as required by our contract with your in-network provider) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the provider-even if you have assigned payment of your claim to someone else. When we pay you or your provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our Plan obligation to you.

Alabama Insurance Fraud Investigation Unit and Criminal Prevention Act

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

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.

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. \

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 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

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.

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 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.

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
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.

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 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 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 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.

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.
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 BCBS Medical Plan** 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 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 BCBS Medical Plan	BlueCross BlueShield of Alabama alabamablue.com or 1-800-292-8868	**BEK BCBS Medical Plan** 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	BlueCross BlueShield of Alabama at alabamablue.com or call 1-800-292-8868
Prescription drug providers	BlueCross BlueShield of Alabama at alabamablue.com or call 1-800-292-8868
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.