MCLANE COMPANY, INC.

McLane Company Welfare Plan

Medical Plan Options:

High Deductible Health Plan

Core PPO Plan

No Deductible PPO Plan

Summary Plan Description

January 1, 2021

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1. INTRODUCTION

This Summary Plan Description (SPD) describes your medical and pharmacy benefits under the McLane Company Welfare Plan (the "Plan").

There are three options offered under the Plan: Core PPO option, No Deductible PPO, and High Deductible Health option (collectively referred to as the "Medical Plan Options"). Section 4.1 of this SPD provides additional information about each Medical Plan Option, such as information regarding Coinsurance percentages, Deductibles, Out-of-Pocket Maximums and benefits payable under the option. Also, certain provisions specific to the Core PPO option, the No Deductible PPO option, and the High Deductible Health option, are noted throughout the document.

You will find terms starting with capital letters throughout this SPD. These terms are generally defined in the Definitions section at the back of this SPD, or they may be defined in the specific section where they are used.

This SPD is only a summary of the Medical Plan Options and does not list all details of these options. All statements made in this SPD are subject to and controlled by the terms of the Medical Plan Options as they appear in the official Plan documents. In the event of a conflict between this SPD and the Plan documents, the Plan documents will control since this is only a summary of the Medical Plan Options. You may obtain a copy of the Plan documents by requesting a copy from your local Human Resources Department. You may be required to pay reasonable copying costs for the Plan documents.

2. ELIGIBILITY - EFFECTIVE DATE

2.1 Eligibility for Coverage – Full-Time Teammates

If you are an eligible, full-time Teammate, you are eligible to elect a Medical Plan Option (subject to any applicable waiting period) if:

- you normally work at least 30 hours per week; and
- you live within the Medical Plan Option Service Area. You must make the election for coverage under a Medical Plan Option by the deadline discussed under the section entitled "Initial Deadline to Apply for Coverage" below.

You must meet certain other requirements to be eligible for the High Deductible Health Plan option, as discussed below.

2.2 Waiting Period for Full-Time Teammates

If you are an eligible, full-time Salaried Teammate or Driver, you are eligible to elect a Medical Plan Option on the date of hire. If you are an eligible, full-time Hourly Teammate other than a Driver, you are eligible to elect a Medical Plan Option effective on the 60th Day of Active Service.

You must make the election for coverage under a Medical Plan Option by the deadline discussed under the section entitled "Initial Deadline to Apply for Coverage" below.

If you are an eligible, full-time Teammate who was previously covered under a Medical Plan Option and your coverage ceased, or if your coverage ceased because you were no longer employed as an eligible Teammate, you are not required to satisfy any Waiting Period if you again become an eligible Teammate within 90 days after the date your coverage originally ceased.

Teammates residing in any country outside the United States who return to permanently reside in the United States immediately gain eligibility for coverage under the Medical Plan Options when the Teammate begins to reside in the Medical Plan Option Service Area and is otherwise eligible for coverage under the Medical Plan Options.

2.3 Initial Deadline to Apply for Coverage

Salaried Teammates and Drivers must complete the enrollment process within 30 days of becoming eligible. Hourly Teammates other than Drivers must complete the enrollment process before the end of the Waiting Period. Otherwise, the Teammate will have to wait until the next annual Open Enrollment Period to enroll (unless a special exception applies). Open Enrollment Period elections go into effect at the beginning of the next Plan Year. The enrollment process must be completed in the form and manner required by the Company.

You will become covered on the first day that you are eligible following your election if you are in Active Service on that date. However, an exception to the Active Service requirement will be made if you are not in Active Service on that date due to a Health Status-Related Factor. However, no coverage will be offered until you complete one day of Active Service.

If you are a Salaried Teammate or a Driver and you do not enroll in a Medical Plan Option within 30 days after the date you initially become eligible, or before the end of your Waiting Period if you are an Hourly Teammate other than a Driver, you will be required to wait until the next annual Open Enrollment Period to enroll (unless a special exception applies).

2.4 Eligibility for Coverage – Variable Hour Teammates

Variable hour (such as part-time) Teammates hired in 2019 and later must work an average of at least 30 hours per week during a 12- month measurement period in order to be eligible for coverage. If this requirement is met, the variable hour Teammate will be eligible for coverage for a 12-month period. The variable hour Teammate will need to continue to meet this 30-hour per week requirement in order to continue to be eligible for coverage. This determination is made every year, and if the Teammate does not meet the requirement, the Teammate will not be eligible for coverage for the following year.

The initial 12-month measurement period will be based on your date of hire. Each subsequent 12-month measurement period will begin October 15 and end the following October 14 (October to October Period).

The initial 12-month measurement period will start on the first day of the month on or after your date of hire and will end on the last day of the month on or after the one-year anniversary of your hire date. If you meet the 30 hour requirement during your first 12-month measurement period and you timely elect coverage, coverage will begin no later than the first day of the second calendar month on or after the first anniversary of your date of hire and will run for a period of 12 calendar months.

If you meet this requirement in an October to October Period and timely elect coverage, coverage will begin on the January 1 following the end of that October to October Period.

If your average weekly hours worked are less than 30 hours per week, you will not be eligible for Medical Plan Options. However, you may be able to purchase coverage through the Marketplace.

Here are some examples of how these rules work:

<u>Not Eligible during Initial Measurement Period, Becomes Eligible Based on First October to October Period</u>:

- John is hired on June 15, 2019. John's initial measurement period will run from July 1, 2019 through June 30, 2020.

- John works less than 30 hours per week during his initial measurement (July 1, 2019 to June 30, 2020). He is not eligible for the Medical Plan Options.

- John works at least 30 hours per week on average during his first October to October Period (October 15, 2019, through October 14, 2020). He will be eligible for the Medical Plan Options for the period January 1, 2021 through December 31, 2021.

<u>Eligible during Initial Measurement Period, Continues to Be Eligible Based on the October to October Period:</u>

- John works at least 30 hours per week on average during his initial measurement period (July 1, 2019, through June 30, 2020). He is eligible for the Medical Plan Options for the twelve-month period starting on August 1, 2020 and ending July 31, 2021.

- John's first October to October Period will be October 15, 2019 through October 14, 2020. John works at least 30 hours per week on average during this period. He will be eligible for the Medical Plan Options for the period of August 1, 2021 (which begins when his coverage based on his initial measurement period ends) through December 31, 2021.

- John works at least 30 hours per week on average for the next October to October Period (October 15, 2020 through October 14, 2021). He will be eligible for the Medical Plan Options for the period January 1, 2022 through December 31, 2022.

Eligible during Initial Measurement Period, Loses Eligibility Based on Subsequent October to October Period:

- John works at least 30 hours per week on average during his initial measurement period (July 1, 2019, through June 30, 2020). He is eligible for the Medical Plan Options for the twelve-month period starting on August 1, 2020 and ending July 31, 2021.

- John's first October to October Period will be October 15, 2019 through October 14, 2020. John does not work at least 30 hours per week on average during this period. He will not be eligible for the Medical Plan Options for the period of August 1, 2021 (which begins when his coverage based on his initial measurement period ends) through December 31, 2021.

- John's next October to October Period will be October 15, 2020 through October 14, 2021. John works at least 30 hours per week on average during this period. He will be eligible for the Medical Plan Options for the period of January 1, 2022 through December 31, 2022.

2.5 Additional Rules for the High Deductible Health Plan Option

Teammates may only enter and exit the High Deductible Health Plan option through annual enrollment with an election that begins coverage at the beginning of a Plan Year, unless one of the following occurs:

- You are unable to continue coverage due to becoming ineligible to participate in a Health Savings Account (HSA) (as further defined below), or

- You fail to timely and properly establish an HSA, or

- You have a Qualifying Life Event or other permitted election change event that allows you to drop High Deductible Health Plan coverage altogether, (but, if you drop coverage, you won't be able to participate in any of the Company's Medical Plan options until the next Plan Year.)

If you are permitted to drop High Deductible Health Plan coverage due to a Qualifying Life Event or other permitted election change event, you should check to see if other coverage options (outside of the Company's Medical Plan options) might be available to you. For example, you may be able to join a Spouse's plan sponsored by another entity other than the Company depending upon the provisions of the other plan.

Please note you must be eligible under the IRS tax code to contribute to an HSA in order to enroll in the High Deductible Health Plan option.

2.6 Eligibility for Dependent Coverage

You may cover a Dependent effective on the day you become eligible for coverage for yourself, or if later, the day you acquire a new Dependent. Any Dependents that you enroll must be enrolled in the same Medical Plan Option that you are enrolled in.

Dependents must reside in the Medical Plan Option Service Area to be eligible to participate in the Medical Plan Options. Dependents residing in any country outside the United States who return to permanently reside in the United States immediately gain eligibility for coverage under the Medical Plan Options when the Dependent begins to reside in the Medical Plan Option Service Area and is otherwise eligible for coverage under the Medical Plan Options.

2.7 Nondiscrimination Requirements

Neither you nor your Dependents will be denied enrollment for medical benefits under a Medical Plan Option due to a Health Status-Related Factor. Federal law and the Medical Plan Options offered under this Plan prohibit any discrimination in eligibility or cost of coverage because of one or more Health Status-Related Factors.

The benefits described in this SPD shall be administered in accordance with the Americans With Disabilities Act of 1990, the Americans With Disabilities Act Amendments Act of 2008, and any regulations or guidance issued thereunder.

2.8 Rehired Teammates

If you are rehired and your rehire date is within 90 days from your prior termination date and within the same Plan Year, you will be automatically enrolled in the Medical Plan Option that you participated in prior to your termination. You will not be subject to new eligibility Waiting Periods or new Plan Year provisions, such as Deductibles and Out-of-Pocket Maximum accumulations. Your required contribution for the applicable Medical Plan Option coverage will be deducted from your pay on a pre-tax basis beginning with your first paycheck upon rehire.

If you are rehired and your rehire date is later than 90 days from your prior termination date or if you are rehired in a subsequent Plan Year, you will be considered a new Teammate for purposes of this Plan. You may enroll in the same options as other new hires and will be subject to a new eligibility Waiting Period and Plan Year provisions, such as Deductibles and Out-of-Pocket Maximum accumulations.

2.9 Dependent Benefits

For your Dependents (defined below) to be covered, you will have to pay part of the cost of Dependent benefits. Your eligible "Dependents" are:

- your legal Spouse;

- any Child who is:

    - less than 26 years old;

    - a Child of any age if the Child is permanently and totally disabled and incapable of self-sustaining employment by reason of a mental or physical disability and proof of the Child's condition and dependence is submitted to the Claims Administrator within 31 days after the date the Child either attains age 26 or is first eligible under the Plan. In either case, the Child must have been permanently and totally disabled and incapable of self-sustaining employment by reason of a mental or physical disability prior to the date the Child attains age 26. During the next two years the Plan Administrator may, from time to time, require proof of the continuation of such condition and dependence. After that, the Claims Administrator may require proof no more than once a year. Teammates should submit proof to the Claims Administrator.

      The term "Child" includes your natural children, step-children, legally adopted children, children Placed for Adoption, and foster children placed with you by an authorized placement agency or court order. It also includes (a) a child of whom you or your Spouse is the court-ordered legal guardian; (b) a child who is related to you if the child resides in your household and depends on you for support and maintenance, and (c) a child for whom a Teammate has received a court order requiring the Teammate to have financial responsibility for providing coverage. Grandchildren are not eligible for coverage under the Plan unless the Teammate is the court-ordered legal guardian of the child. In the case of a Child with divorced parents where one or both parents have custody of the Child for more than half of the calendar year and where the parents together provide more than half of the Child's support for the calendar year, the Child is treated as a Dependent of both parents. Once legal guardianship ends, the Dependent is no longer eligible to be covered under the Plan.

Anyone who is covered as a Teammate may not be covered as a Dependent. No one may be covered as a Dependent of more than one Teammate.

2.9.1 Dependent Audit Process

The Plan Administrator has the right to verify the Dependents you enroll (or request to enroll) to ensure they meet the eligibility requirements of the Plan. The Plan Administrator (or its designee) will audit the information and documentation you provide to determine if such individuals are Dependents eligible to be covered under the Plan and may require that you furnish additional information or documentation. All documentation and information requested must be provided within the timeframe communicated by the Plan Administrator (or its designee). Such information or documentation required may include, but is not limited to, a marriage license, birth certificate, tax return, and divorce decree. If the audit reveals that any individual is not your Dependent as defined by the Medical Plan Options, coverage will not become effective or will be terminated either on a go forward basis or,

in the case of fraud or intentional misrepresentation, upon 30 days advance notice, as if no coverage was ever in force with respect to such individual. We may also pursue recovery of any Plan benefits paid on behalf of the ineligible Dependent, and, if you have made false statements, it may lead to disciplinary actions up to and including termination of employment.

2.9.2 Effective Date of Dependent Benefits

Your Dependents will be covered on the same date that you become covered as long as you timely complete the Company's enrollment process and elect one of the "Teammate plus Dependent" coverage levels. Salaried Teammates and Drivers must enroll within 30 days of becoming eligible and Hourly Teammates other than Drivers must enroll before the end of their Waiting Period. Variable hour Teammates must enroll within 30 days of becoming eligible. All eligible Dependents as defined above will be included if they are included on your enrollment paperwork and you provide written documentation proving the eligibility of the Dependents within the timeframe communicated by the Plan Administrator.

Your Dependents may be covered only if you are covered. (Exception: Please see the section entitled, "Continuation Required by Federal Law (COBRA) for You and Your Dependents.")

If you do not enroll your Dependents in a Medical Plan Option within the applicable initial enrollment period, you will be required to wait until the next annual Open Enrollment Period to enroll (unless a special exception applies).

2.9.3 Exception for Newborns, Children Adopted and Children Placed for Adoption

Any Dependent child born to, adopted or Placed for Adoption with you while you are covered for medical benefits for yourself under a Medical Plan Option will become covered for medical benefits under that Medical Plan Option on the date of his or her birth, adoption, or Placement for Adoption if you enroll the newborn child, adopted child or child Placed for Adoption under a Medical Plan Option no later than 60 days after the child's birth, adoption or Placement for Adoption.

If you do not elect to cover your newborn child, adopted child or child Placed for Adoption with you by completing the Company's "Qualifying Event Change Form" and the Company's dependent audit process within 60 days from the time of birth, adoption or Placement for Adoption *this child will not have coverage under the Medical Plan Option*. No benefits for Expenses Incurred will be payable including the day of birth. You will be required to wait until the next annual Open Enrollment Period to elect medical benefits for the Child (unless a special exception applies).

2.10 Enrollment After the Open Enrollment Period Has Closed

Generally, if you decline enrollment under a Medical Plan Option during the Open Enrollment Period, you must wait until the next annual Open Enrollment Period to enroll. However, special exceptions apply under the following circumstances:

- loss of eligibility for other health coverage;
- the acquisition of a new Dependent through marriage, birth, adoption or Placement for Adoption; or
- becoming eligible for state premium assistance subsidy.

You must enroll in a Medical Plan Option **within 60 days** of the event giving rise to the special enrollment opportunity.

In the case of loss of coverage or acquiring a new Dependent through marriage, birth, adoption, or Placement for Adoption, you must request enrollment in a Medical Plan Option under this Plan within 60 days (i) after your other coverage ends or (ii) after acquiring your new Dependent by completing a "Qualifying Event Change Form" and providing the necessary supporting documentation. You may obtain this form from your local Human Resources Department.

If an Open Enrollment Period is "active," meaning that you must make an affirmative election in order to enroll, if you do not make an active, affirmative election you will be deemed to have elected no coverage. If an Open Enrollment Period is "passive," meaning that your prior coverage will continue unless you elect otherwise, if you do not make an affirmative election you will be deemed to have elected the same coverage that you participated in during the prior Plan Year. You will be notified whether an Open Enrollment Period will utilize an active or passive enrollment process.

2.10.1 Special Enrollment – Loss of Eligibility for Other Coverage

If you declined enrollment under a Medical Plan Option for yourself or your eligible Dependents during the Open Enrollment Period because you had health coverage outside of the Plan and you lose this other health coverage, you may be able to enroll yourself and your Dependents in a Medical Plan Option (even if the Open Enrollment Period has closed) if the following conditions are met:

- loss of eligibility for the prior coverage; or
- the employer ceased employer contributions for the prior coverage; or
- if such prior coverage was continuation coverage under COBRA, the continuation period has been exhausted.

However, you must enroll in a Medical Plan Option **within 60 days** after losing or exhausting prior coverage in order to be eligible for this special enrollment.

If you do not complete and return the "Qualifying Event Change Form" with supporting documentation within 60 days after your other coverage ends, you will be required to wait until the next annual Open Enrollment Period to elect coverage (unless a special exception applies).

A loss of eligibility for coverage includes (but is not limited to) a loss due to:

- legal separation, divorce, annulment, death, termination of employment, reduction in number of hours of employment, the cessation of Dependent status (for example a Dependent child attains the other plan's limiting age), and any loss of eligibility after a period measured by reference to any of these events;

- an HMO or other arrangement provided in an individual market no longer provides benefits to an individual because the individual no longer resides, lives or works in the service area;

- an HMO or other arrangement provided in a group market no longer provides benefits to an individual because that individual no longer resides, lives or works in the service area and there is no other benefit package available to the individual to transfer to in that group market; and

- the plan no longer offers any benefits to a class of similarly situated individuals.

Coverage timely elected in the case of a loss of coverage will be effective on the date the event occurred. Pre-tax premium deductions will begin at the end of the first full pay period following the event date. You will not be charged for retroactive coverage added in these instances.

2.10.2 Special Enrollment – Acquisition of New Dependent

If you acquire a new Dependent through marriage, birth, adoption or Placement for Adoption, you may enroll your eligible Dependent and yourself, if you are not already enrolled, **within 60 days of such event**. Only the eligible Teammate, eligible Spouse and newly eligible Dependent may enroll pursuant to a special enrollment right of a non-Spouse Dependent. This means that other non-Spouse Dependents who were previously eligible are not eligible to be covered under the Medical Plan Options as "tag-along" Dependents. For example, if a Teammate who is married with one Dependent child previously elected Teammate-only coverage, but during the Plan Year, the Teammate and Spouse adopt a second child, only the Spouse and the new second Dependent Child may be enrolled. The first Dependent Child who was previously eligible but was not covered may not be added to the Plan as a tag-along Dependent when the newly adopted Dependent Child is added.

You must enroll in a Medical Plan Option **within 60 days** after acquiring a new Dependent through marriage, birth, adoption, or Placement for Adoption.

If you do not complete and return the "Qualifying Event Change Form" with supporting documentation within 60 days after acquiring a new Dependent through marriage, birth adoption or Placement for Adoption, you will be required to wait until the next annual Open Enrollment Period to elect coverage (unless a special exception applies).

Coverage timely elected related to the acquisition of a Dependent due to marriage, birth, adoption or Placement for Adoption will be effective on the date the event occurred. Pre-tax premium deductions for Teammates will begin at the end of the first full pay period following the event date. Teammates are not charged for retroactive coverage added in these instances.

2.10.3 Special Enrollment – Becoming Eligible for Premium Assistance

You may also be able to enroll yourself or your Dependents in a Medical Plan Option under the Plan after the Open Enrollment Period has closed if you or your Dependents become eligible for premium assistance from the government or lose eligibility for coverage under Medicaid or CHIP. However, you must request coverage not later than 60 days after becoming eligible for premium assistance or the loss of coverage under Medicaid or CHIP.

If you or your Dependents gain eligibility for premium assistance from the government or lose eligibility for coverage under Medicaid or CHIP, you must request special enrollment in a Medical Plan Option under this Plan within 60 days after becoming eligible for premium assistance or losing eligibility for Medicaid or CHIP coverage by completing a "Qualifying Event Change Form" and providing the necessary supporting documentation. You may obtain this form from your local Human Resources Department.

If you do not complete and return the "Qualifying Event Change Form" with supporting documentation within 60 days after becoming eligible for premium assistance from the government or losing eligibility under Medicaid or CHIP, you will be required to wait until the next annual Open Enrollment Period to elect coverage (unless a special exception applies).

In the case of becoming eligible for premium assistance from the government or losing eligibility for coverage under Medicaid or CHIP, your coverage will be effective on the date the event occurred.

2.11 Changes in Elections – Qualifying Life Events and Other Permitted Election Changes

2.11.1 Qualifying Life Events

The elections that you make under the Plan generally must remain in place for the entire Plan Year, unless a special exception applies. The Medical Plan Options under the Plan operate in conjunction with the Flexible Benefit Plan, and the Flexible Benefit Plan rules limit your ability to make changes to the coverage you have selected.

You may only make changes in the coverage you elected (or declined) during the annual Open Enrollment Period if you or your Dependents are eligible for Special Enrollment (as described above) or if you experience a Qualifying Life Event or other permitted election change as described in this Section 2.11.

If you do experience a Qualifying Life Event, you must request the election change in writing on a "Qualifying Event Change Form" within 60 days of the Qualifying Life Event or other permitted election change event.

The following are Qualifying Life Events:

- Change in legal marital status due to marriage, the death of a Spouse, divorce annulment or legal separation;
    - Coverage for your Dependent who is your lawful Spouse *automatically* terminates upon divorce. In that event, please complete a "Qualifying Event Change Form" and refer to the section entitled "CONTINUATION REQUIRED BY FEDERAL LAW (COBRA) FOR YOU AND YOUR DEPENDENTS/General COBRA Notice" for more information.
- Change in number of Dependents due to birth, adoption, Placement for Adoption or death of a Dependent;
- Change in employment status of Teammate or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical Leave Act (FMLA), or change in worksite;
- Changes in employment status of Teammate or Dependent resulting in eligibility or ineligibility for coverage;
- Change in residence or work location of a Teammate or Dependent (if that change results in the loss or gain of access of current coverage), including a change in residence that occurs when a Teammate and/or Dependent(s) residing in any country outside the United States return(s) to permanently reside in the United States.
- Changes that cause a Dependent to become eligible or ineligible for coverage;
- Intention to enroll in a Qualified Health Plan through the Marketplace. You may elect to drop coverage under a Medical Plan Option that provides minimum essential coverage if you are eligible to buy coverage in the Marketplace. You (and any of your Dependents who were covered under a Medical Plan Option prior to the revocation of your election) must intend to enroll in coverage under a Marketplace or Exchange no later than the first day of the second month following the month that includes your revocation of coverage under a Medical Plan Option that provides minimum essential coverage; or

- Reduction of hours with a corresponding intention to enroll in another plan offering minimum essential coverage. You may elect to drop coverage under a Medical Plan Option that provides minimum essential coverage if your employment status changes from a position in which you were reasonably expected to average at least 30 hours of service per week to a position in which you will reasonably be expected to average less than 30 hours of service per week. You (and any of your Dependents who were covered under a Medical Plan Option prior to the revocation of your election) must intend to enroll in coverage under a medical plan that provides minimum essential coverage no later than the first day of the second month following the month that includes your revocation of coverage under a Medical Plan Option that provides minimum essential coverage.

You are only permitted to make a Qualifying Life Event change if it is on account of and corresponds with that Qualifying Life Event, as determined by the Plan Administrator. This is referred to as the "consistency rule." For example, if one of your Dependents ceases to satisfy the eligibility requirements for coverage due to a Qualifying Life Event, you may only elect to drop coverage for that Dependent. Dropping coverage for any other Dependent will not "correspond" with the Qualifying Life Event so it will not meet the "consistency rule". Consistency rule information is available from your Human Resources Department.

Any election change made will be effective on the first day of the month after the Plan Administrator receives your completed Qualifying Event Change Form except in the case of marriage, birth, adoption, Placement for Adoption (defined below) or divorce. In the case of marriage, birth, adoption, Placement for Adoption, or divorce, the election change will be effective retroactively back to the date that the election change event occurred. Pre-tax premium deductions for Teammates will begin at the end of the first full pay period following the event date. If notice is not timely provided due to divorce, no refunds will be provided absent unusual circumstances.

2.11.2 Other Permitted Election Changes

The following are other events that permit you to make an election change under a Medical Plan Option under the Plan during the Plan Year, if you request the election change in writing on a "Qualifying Event Change Form" within 60 days of the event and you provide documentation as required by the Plan Administrator to support the change:

2.11.2.1 Judgment, Decree or Order

You may change your election during the Plan Year if the change results from, and is consistent with, a judgment, decree or order pursuant to a divorce, legal separation, annulment or change in legal custody requiring health coverage for your child. You may only cancel your election for coverage for the child if health coverage is provided to the child by another person as required by a judgment, decree or order.

2.11.2.2 Medicare Eligibility/Entitlement

You may change your election to cancel or reduce coverage due to entitlement to Medicare, or to enroll or increase coverage due to loss of Medicare eligibility.

2.11.2.3 Change in Another Employer Plan

The Medical Plan Option under the Plan may permit a prospective election change that is made on account of and corresponds with a change made under another employer plan if:

(i) The other employer plan permits participants to make election changes as provided by law; or

(ii) The other employer plan permits participants to make elections for a period of coverage different from the period of coverage under the Medical Plan Options.

2.11.2.4 Government or Educational Plan

The Medical Plan Options under the Plan may permit you to make an election to add coverage prospectively if you, your Spouse, or Dependent loses group health coverage sponsored by a governmental or educational institution including the following:

- A CHIP program;
- A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization;
- A state health benefits risk pool; or
- A Foreign government group health plan.

2.11.2.5 Automatic Cost Change

If your costs under one of the benefit options increases or decreases, and the Plan Administrator determines an election change is permitted by the Flexible Benefit Plan and the law, your election with respect to the cost will be adjusted to correspond to the changes. Your withholding election amount will be changed automatically to correspond with the cost change.

2.11.2.6 Significant Cost Changes

If the cost under a benefit option is changed significantly during a Plan Year, the Plan Administrator may allow you to make a corresponding election change.

- Significant Cost Decreases

If the cost of any benefit option under this Plan significantly decreases, the Plan Administrator may allow you to elect the benefit option which had a significant decrease in cost, even if you have elected another benefit option or have not previously participated in benefit option under the Plan.

- Significant Cost Increases

  If the cost for a benefit option significantly increases, the Plan Administrator may allow you to make corresponding changes to your benefit option election, including revoking your election for the benefit option which significantly increased in cost. In such a case, you may either elect to receive on a prospective basis a new benefit option that provides similar coverage or you may drop coverage if no other benefit option providing similar coverage is available.

2.11.2.7 Significant Coverage Change

If the coverage under a benefit option is changed significantly during a Plan Year, the Plan Administrator may allow you to make a corresponding election change.

- Reduction in Coverage

  If a benefit option has a significant reduction in coverage (other than a loss of coverage described in the paragraph below), such as a significant increase in the Deductible, the Copay, or out of pocket expenses, the Plan Administrator may allow you to revoke your election for that coverage and elect, on a prospective basis, to receive coverage under another benefit option providing similar coverage.

- Loss of Coverage

  If a benefit option has a "loss of coverage," the Plan Administrator may allow you to revoke your election for such benefit option and elect another benefit option providing similar coverage or drop coverage if no other benefit option providing similar coverage is available.

  A "loss of coverage" means a complete loss of coverage under the benefit option including the elimination of a benefit option or an HMO ceasing to be available in the area an individual resides.

  In addition, the Plan Administrator may treat the following as a loss of coverage:

  - A substantial decrease in the health care providers available under the option;

- A reduction in the benefits for a specific type of health condition or treatment with respect to which the Teammate or Teammate's Spouse or Dependent is currently in a course of treatment; or

- Any other similar fundamental loss of coverage.

- New or Improved Coverage

  If a benefit option is added during a Plan Year or if an existing benefit plan option is significantly improved, the Plan Administrator may allow eligible Teammates (whether or not they previously made an election under the Plan) to revoke their election under the Plan and make an election, prospectively, for coverage under the new or improved benefit package option.

If you do not complete and return the "Qualifying Event Change Form" with supporting documentation within 60 days after a Qualifying Life Event or other permitted change event, you will be required to wait until the next annual Open Enrollment Period to elect or change coverage (unless a special exception applies).

If you have questions about whether an event will permit an enrollment or change in election under the Flexible Benefit Plan, please ask the Plan Administrator.

2.11.2.8 Qualified Medical Child Support Order

If you or the Plan receives a medical child support order requiring you to provide health coverage for a child, you may be required to provide health coverage for that child if the Plan Administrator determines that the medical child support order is a Qualified Medical Child Support Order.

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law, or a National Medical Support Order (as defined by section 609(a)(5)(C) of ERISA), which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a Participant or beneficiary is eligible;

2. the order specifies your name and last known address, and the Child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the Child's mailing address;

3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

4. the order states the period to which it applies; and

5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The Qualified Medical Child Support Order may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan, except that an order may require the Plan to comply with state laws regarding child health care coverage. If you need additional information concerning Qualified Medical Child Support Orders, please contact the Plan Administrator for a copy of the Plan's Qualified Medical Child Support Order procedures, which will be furnished to you free of charge.

The Core PPO option is the default medical coverage for the employee and the alternate recipient when there is a Qualified Medical Child Support Order that does not specify the coverage, unless you do not reside in the Medical Plan Option Service Area for the Core PPO option.

The child (and you, if you are not already enrolled) will be automatically enrolled in the applicable Medical Plan Option after the order has been determined to be a Qualified Medical Child Support Order. Although the Plan may receive the medical child support order from another party, you are still required to notify your local Human Resources Department of the order. Please contact your local Human Resources Department to get a "Qualifying Event Change Form," complete the form, attach a copy of the order and return it to your local Human Resources Department.

3. PREFERRED PROVIDER MEDICAL BENEFITS

The Medical Plan Options under this Plan provide medical benefits for Covered Expenses provided by Participating Providers (In-Network) and Non-Participating Providers (Out-of-Network). The network for all Medical Plan Options is Blue Cross and Blue Shield of Texas' (BCBSTX) PPO network. Please see section 4 below for information concerning the advantages of using Participating Providers and how to locate Participating Providers in the BCBSTX Network.

To receive medical benefits under any of the Medical Plan Options, you and your Dependents may be required to pay a portion of the Covered Expenses. That portion is the Copay, Deductible and Coinsurance. You are also required to contribute to the cost of this coverage by paying a monthly contribution. The monthly contribution amount will be provided to you in your enrollment materials and will be paid by you in bi-weekly contribution amounts. Please see the "Cost to You" section in this SPD.

If you are unable to locate a Participating Provider for a certain specialty within 75 miles or an OB/GYN, pediatrician, family practitioner, or internal medical Physician within 30 miles of your area who can provide you with a service or supply that is covered under a Medical Plan Options under the Plan, you must call the number on the back of your ID card to obtain authorization for Non-Participating Provider coverage. Your request may or

may not be approved. If you obtain authorization for services provided by a Non-Participating Provider, benefits for those services will be covered at the Participating Provider benefit level. Failure to obtain authorization and approval will result in those services being covered at a Non-Participating Provider level.

If a Participant receives services that are not covered by the Medical Plan Options or are listed in the "Expenses Not Covered / Exclusions" list, the Participant is responsible for the full cost of those services. If a Participant receives services that may be covered by the Medical Plan Option but fails to meet prior approval requirements as listed in this SPD, then services may be denied or covered at a lower level of benefit.

3.1 For You and Your Dependents

The Medical Plan Options under the Plan will pay benefits for Covered Expenses incurred by you or any of your covered Dependents as shown in the Schedule of Benefits. Payment of any benefits will be subject to any applicable Copays, Coinsurance, Deductibles and benefit maximums shown in the Schedule of Benefits.

Your benefits are calculated on a calendar year benefit period basis unless otherwise stated. At the end of a calendar year, a new benefit period starts for each Participant for purposes of calculating required Copays, Coinsurance, Deductibles, Out-of-Pocket Maximums and other maximums and limitations under the Plan.

3.1.1 Second Opinion Surgical Benefits

If, as a result of an Injury or a Sickness, you or any of your Dependents, while covered for these benefits and prior to the performance of an Elective Surgical Procedure recommended by a surgeon, ask for an opinion from another Physician who is qualified to diagnose and treat that Injury or Sickness, the fee charged for that opinion will be considered a Covered Expense. Charges made for diagnostic laboratory or x-ray examinations asked for by the Physician who gives that opinion will also be considered Covered Expenses.

Payment will be made whether or not the surgical procedure is performed. Payment will be subject to all terms of the Medical Plan Option except as otherwise provided in this section.

3.2 Limitations

No payment will be made for Charges incurred in connection with limitations listed in Section 6, "Expenses Not Covered/Exclusions."

3.3 Copays and Deductibles

The benefits of the Medical Plan Options will be available after satisfaction of the applicable Copay amounts and Deductibles as shown on your Schedule of Benefits for In-Network and Out-of-Network Benefits. Copays are dollar amount expenses to be paid by

you or your Dependent to the provider for the services received. If the services provided by the Participating Provider require a return office visit, a new Copay amount will be required.

Deductibles are expenses paid by you or your Dependent to the provider. Deductible amounts are separate from Copays. Individual Deductible means the amount that must be satisfied by each of you and your covered Dependents each calendar year before benefits become payable by the Plan for that individual. Family Deductible means the amount that must be satisfied in total by you and your covered Dependents each calendar year before benefits become payable by the Plan. Once you meet the Family Deductible, benefits may be payable by the Plan for you and your covered Dependents even if the Individual Deductibles have not been met. Please see additional information about Deductibles below.

You should present your Medical Plan Option ID Card to all providers when receiving In-Network or Out-of-Network benefits to make sure you receive the coverage and benefits you are entitled to. With respect to the High Deductible Health Plan option, it is very important that you send all of your medical claims to BCBSTX and all of your pharmacy claims to Express-Scripts for processing so that your eligible Charges will be applied toward the Deductible each calendar year. It is also necessary to file all medical claims under the High Deductible Health Plan with BCBSTX so that you will be able to take advantage of the discount provider charges when you use an In-Network provider.

For all Medical Plan Options except for the High Deductible Health Plan option, there is an Individual Deductible requirement. This Individual Deductible must be met by each Participant each calendar year except that the following exceptions apply:

- If you have several covered Dependents, all Charges used to apply toward each Participant's Individual Deductible will be applied toward the "Family Deductible" amount shown on your Schedule of Benefits. When that Family Deductible amount is reached, no further Individual Deductibles will have to be satisfied for that Plan Year. No Participant will contribute more than the Individual Deductible amount to the Family Deductible amount.

- Eligible expenses applied toward satisfying any Out-of-Network Deductible will apply toward satisfying any In-Network Deductible.

The High Deductible Health Plan option also has a Family Deductible Amount which caps the Deductible amount that must be met by your family each calendar year. There is no Individual Deductible if two or more participants are covered under the High Deductible Health Plan. Please see the Schedule of Benefits for the High Deductible Health Plan option for the Deductible amount that must be met by you and your family before benefits are payable under the High Deductible Health Plan option.

Following is how the Deductible amounts work under the High Deductible Health Plan option:

- If you have one or more covered Dependents, Charges for all Participants will be applied toward the Family Deductible amount shown on the Schedule. When that Family Deductible amount is reached, no further Deductibles will have to be satisfied for that Plan Year.

  Eligible pharmacy expenses will only apply toward satisfying the In-Network Deductible.

Copays and Deductibles are *in addition* to any Coinsurance.

After meeting the In-Network Deductible amounts totaling the Family Deductible amount listed in the Schedule of Benefits for your applicable Medical Plan Option, your family need not satisfy any further In-Network Deductibles for the rest of that Plan Year.

After meeting the Out-of-Network Deductible amounts totaling the Family Deductible amount listed in the Schedule of Benefits for your applicable Medical Plan Option, your family need not satisfy any further Out-of-Network Deductibles for the rest of that Plan Year.

As previously mentioned, the Family Deductible is designed to benefit a family by capping the amount your family spends on the Deductible each Plan Year. For example, using the Core Medical Plan Options, if there was not a Family Deductible, in a family of four, every person would have to meet the Individual Deductible ($1,250 for Core PPO option). A family would spend $5,000 before plan coverage would begin. Instead, with a Family Deductible, the amount a family must spend on the Deductible is capped at $3,000 (only 2.4 times the Individual Deductible).

3.4 Coinsurance

The term Coinsurance means the percentage of Charges for Covered Expenses that a Participant is required to pay under the Medical Plan Options after any applicable Copays and Deductibles are satisfied.

3.5 Out-of-Pocket Maximums

The Medical Plan Options under the Plan have a "Full Payment" provision that limits the amount of expenses that you or your family would be required to pay in any Plan Year (called the "Out-of-Pocket Maximum").

Out-of-pocket expenses are Covered Expenses incurred for Charges made by Participating (In-Network) and Non-Participating Providers (Out-of-Network) for which no payment is provided because of the Coinsurance.

Medical Deductibles, Copays, and Coinsurance and count toward the Medical Out-of-Pocket Maximum.

Pharmacy Copays, Coinsurance and any amount paid for generic conversion count toward the Pharmacy Out-of-Pocket Maximum. For generic conversion, if a member is prescribed a brand drug when script allows a generic substitution, or if a member chooses a brand, the difference in cost as well as the applicable brand Coinsurance will apply.

The amounts over the Allowable Amounts do not count toward the Out-of-Pocket Maximum for in-network or out-of-network benefits.

For the High Deductible Health Plan only, all Deductibles and Prescription Drug Copays apply toward the Medical Out-of-Pocket Maximum.

3.5.1 Full Payment Area (Participating/In-Network Provider Covered Expenses)

When a person has satisfied the Individual Out-of-Pocket Maximum shown in the Schedule of Benefits in any Plan Year, benefits for that person for Covered Expenses incurred due to Charges made by Participating Providers during the rest of that Plan Year will become payable at the rate of 100%.

When you and your Dependents, have satisfied the Family Out-of-Pocket Maximum shown in the Schedule of Benefits in any Plan Year, benefits for you and all of your Dependents for Covered Expenses incurred due to Charges made by Participating Providers during the rest of that Plan Year will become payable at the rate of 100%.

You should note that the Individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum do not include (i) services, supplies, or charges limited or excluded by the Plan, (ii) expenses not covered because a benefit maximum has been reached, and (iii) penalties applied for failure to preauthorize.

3.5.2 Full Payment Area (Non-Participating/Out-of-Network Provider Expenses)

When a person has satisfied the Individual Out-of-Pocket Maximum shown in the Schedule of Benefits in any Plan Year, benefits for that person for Covered Expenses incurred due to Charges made by Non-Participating Providers during the rest of that Plan Year will become payable at the rate of 100%.

When you and your Dependents have satisfied the Family Out-of-Pocket Maximum shown in the Schedule of Benefits in any Plan Year, benefits for you and all of your Dependents incurred due to Charges made by Non-Participating Providers during the rest of that Plan Year will become payable at the rate of 100%.

All benefit Deductibles will continue to apply. Any Deductible amounts, if not yet satisfied, will continue to apply until they are satisfied. In addition, you should note that the Individual Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum do not include (i) services, supplies, or charges limited or excluded by the Plan, (ii) expenses not

covered because a benefit maximum has been reached, and (iii) penalties applied for failure to preauthorize.

3.6 Accumulation of Deductible and Out-of-Pocket Maximums

Eligible Expenses Incurred for Participating Provider Charges will be used to satisfy the In-Network Deductible and Out-of-Pocket Maximums.

Eligible Expenses Incurred for Non-Participating (Out-of-Network) Provider Charges will be applied toward satisfaction of the Out-of-Network Deductible and Out-of-Network Out-of-Pocket Maximums.

3.7 Emergency and Urgent Care Services

The Medical Plan Options under the Plan cover Emergency Services and Urgent Care services. You and your Dependent pay the Emergency Services or Urgent Care services Copays or Coinsurance shown in the Schedule of Benefits. For information on Emergency Services and Urgent Care services, including any restrictions, refer to the section entitled, "Preferred Provider Medical Benefits."

3.8 Covered Hospital Expenses

	In-Network	Out-of-Network
Hospital Room and Board Daily Limit for a private or semiprivate room	The Hospital's negotiated daily rate	The Hospital's average **semiprivate room daily rate**
Hospital Room and Board Daily Limit for an Intensive Care Unit	The Hospital's negotiated daily rate	The Hospital's most common daily rate for Intensive Care
Other Health Care Facility Daily Limit	The Facility's negotiated daily rate	The Facility's semiprivate rate
Hospice Room and Board Daily Limit	The Hospice Facility's negotiated rate	The Hospice Facility's semiprivate rate

3.9 Certification Requirements

3.9.1 Preauthorization/Pre-Admission Certification/Continued Stay Review for Hospital Confinement/Admission

Preauthorization establishes in advance the Medical Necessity of certain care and services covered under the Medical Plan Options offered under the Plan. This ensures that the preauthorized care and services described below will not be denied on the basis of Medical

Necessity. However, Preauthorization does not guarantee payment of benefits. Coverage is always subject to other requirements of the Medical Plan Options, such as, limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

Hi-tech radiology services provided in Texas, Oklahoma, New Mexico and Illinois should be pre-approved by BCBSTX' s subcontractor to ensure they meet the medically necessity requirements before being performed.

The following types of services (In-Network and Out-of-Network) require Preauthorization:

- Inpatient Hospital Services;
- Inpatient Services at Other Health Care Facilities;
- Inpatient treatment of Mental Health or Substance Abuse;
- Inpatient Infertility Services;
- Home Health Services;
- Skilled Nursing Facility;
- Hospice Inpatient services;
- Organ transplant.

There are other services that require preauthorization. You should call the Customer Service Helpline at 1-866-363-7936 to find out if a service must be preauthorized before scheduling the service.

Preauthorization is simple. You or your Dependent, your Physician, provider of services, or a family member should request Preauthorization prior to any non-emergency treatment described above. In the case of an elective inpatient admission, the call for Preauthorization should be made at least 2 working days before you are admitted unless it would delay Emergency Care. In the case of an admission for Emergency Services, you must contact the Review Organization within 48 hours after the admission.

When an **inpatient admission** is preauthorized, a length-of-stay is assigned. The Medical Plan Options are required to provide a minimum length of stay in a Hospital facility for the following:

Maternity Care:

48 hours following an uncomplicated vaginal delivery

96 hours following an uncomplicated delivery by caesarean section

If you require a longer stay than was first preauthorized, your provider may seek an extension for the additional days. Benefits will not be available for Room and Board Charges that are not Medically Necessary.

Preauthorization for **Home Health Services, Skilled Nursing, and Hospice** may be obtained by having the agency or facility providing the services contact the Claims Administrator to request Preauthorization. The request should be made:

- Prior to initiating Extended Care Expense or Home Infusion Therapy;
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

The Claims Administrator will review the information submitted prior to the start of Home Health Services, Skilled Nursing, and Hospice services. The Claims Administrator will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If the care is to take place in less than one week, the agency or facility should call the applicable telephone number listed below. If the Claims Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

All inpatient treatment of **Substance Use Disorder, Serious Mental Illness, and Mental Health Care** should be preauthorized. Your provider should contact the Claims Administrator for the names of Participating Providers. Participants or their provider should contact the Mental Health Helpline below for a referral to Participating Providers who have entered into a managed care arrangement with the Claims Administrator to furnish services and supplies for Substance Use Disorder, Serious Mental Illness or treatment for Mental Health Care.

3.9.2 Preauthorization HelpLine

To satisfy all medical Preauthorization requirements for inpatient Hospital Admissions, Extended Care Expense, or Home Infusion Therapy, call the Medical Preauthorization Helpline, Monday through Friday, 6:00 a.m. – 6:00 p.m., Central Time. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management Nurse will follow up with your provider's office.

Toll-free: 1-800-441-9188

To satisfy Preauthorization requirements for Substance Use Disorder, Serious Mental Illness, or Mental Health Care, call the Mental Health/Substance Use Disorder Preauthorization Helpline at:

Toll-free: 1-800-528-7264

The Mental Health/Substance Use Disorder Preauthorization Helpline is available 24 hours a day, 7 days a week.

3.9.3 Penalties for Failure to Pre-Certify Hospital Stay

Other than in connection with childbirth as explained in Section 8.2 below, Covered Expenses incurred will not include the first $750 of Hospital Charges made for each separate admission to the Hospital unless Preauthorization is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission. If Preauthorization is not obtained for the services listed above:

- The Claims Administrator will review the Medical Necessity of your treatment prior to the final benefit determination;

- If the Claims Administrator determines the treatment or service is not Medically Necessary, benefits will be denied; or

- In connection with a Hospital Admission, you may be responsible for a $750 penalty. The penalty charge will be deducted from any benefit payment which may be due for the admission.

- If a Hospital Admission or extension for any treatment or service described below is not preauthorized and it is determined that the admission or extension was not Medically Necessary, benefits will be reduced or denied.

Some providers will pre-certify for you. However, it is the Teammate's responsibility to ensure that pre-certification has been obtained BEFORE the procedure is performed. Failure to obtain pre-certification will result in non-compliance penalties and/or reduction in benefits.

4. MEDICAL PLAN OPTION BENEFITS

When you select a Participating (In-Network) Provider, the Medical Plan Options pay a greater share of the costs than if you were to select a non-Participating (Out-of-Network) Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and facilities in Blue Cross and Blue Shield's (BCBSTX) network. You will find the most current listing of Participating Providers online. Participants may go to https://www.bcbstx.com/mclane or call Customer Service Helpline at 1-866-363-7936.

The website administrators have made reasonable efforts to validate that the list of Participating Providers displayed is up to date and accurate. Whether you obtain the name of a Participating Provider from customer service or an online listing, it is your responsibility to:

- call the provider to confirm that the provider is a current Participating Provider in the applicable network prior to making an appointment; and

- verifying this information again at the time of your appointment;

If the provider is not a Participating Provider the covered service will only be eligible for Out-of-Network benefits.

PPACA requires non-grandfathered health plans and policies to provide coverage for "preventive care services" without cost sharing (such as coinsurance, deductible or copayment), when using a network provider. Services may include screenings, immunizations, and other types of care, as recommended by the federal government. The regulation mandates certain Preventive Care measures for infants, children, adolescents and women. These recommendations will be in place until new requirements for prevention are issued by the United States Preventive Services Task Force or appear in comprehensive guidelines supported by the Health and Human Resources and Services Administration (HHSA). A general list of covered services can be found in the detailed Schedule of Benefits listed below. Members can call Customer Service at the number on their member ID card for details on how these benefits apply to their coverage and the most up-to-date list of covered preventive services, including those paid without any cost-sharing.

FDA-approved contraceptive/screening methods, including sterilization procedures for women with reproductive capacity and tubal ligation, include prescribed over the counter female contraceptives and medical devices. Medical devices include IUD, diaphragm, cervical cap, and certain contraceptive implants, but not all brands and products are covered. Please call member services to find out which specific items are covered by the Plan. Tubal ligation is a covered service. If it is performed at the same time as another procedure, the Plan will cover the tubal ligation procedure at 100% and all other services will receive the applicable benefit. Vasectomies and hysterectomies are not considered preventive services and do not receive 100% coverage but normal benefits will apply.

Breastfeeding support/supplies/counseling includes: comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period. Manual and electronic breast pumps will be covered with no cost–share but this does not apply to hospital grade pumps. If a member wishes to use this benefit, they may purchase the pump and submit a paper claim for reimbursement**.** Hospital grade breast pumps are only eligible for rental, not purchase. If the provider is contracted with BCBSTX, the member will not have to pay any money up front or file a claim**.**

Screening for domestic violence is generally conducted by a Physician during a woman's annual exam visit and covered as part of a woman's annual preventive exam.

4.1 The Schedule of Benefits

The Schedule of Benefits set forth below is a brief summary of the maximum benefits payable under a Medical Plan Option. For a more detailed description of each benefit, refer to the appropriate section in this SPD that describes the particular Medical Plan Option.

Benefits for Covered Expenses due to Participating (In-Network) and Non-Participating Provider (Out-of-Network) Charges are payable as follows, subject to the Plan Year limits.

Coinsurance percentages listed on the Schedule of Benefits are the Participant's responsibility.

In-Network services must be provided by a Participating Provider.

Out-of-Network services are provided by Non-Participating Providers and will have a higher cost. In addition to the Out-of-Network Participant responsibility listed below, the Participant will also be responsible for any difference in cost between billed services and the Allowable Amount the Plan pays.

4.1.1 Core PPO Option

Core PPO Option		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Annual Deductible (excludes Copays)	$1,250 Individual $2,500 Family	$2,500 Individual $5,000 Family
Annual Out-of-Pocket Maximum	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Prescription Drug Annual Out-of-Pocket Maximum	$3,000 Individual $6,000 Family	
Lifetime Maximum Benefit	Unlimited	
Primary Office Visit (including Virtual Visits)	$25 Copay per visit*	40% after Deductible
Specialist Office Visit (including Virtual Visits)	$75 Copay per visit*	40% after Deductible
Urgent Care Facility	$75 Copay per visit	40% after Deductible

* Deductible and applicable Coinsurance applies when x-ray and lab are processed by a separate provider.

Core PPO Option		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Hospital Emergency Room Number of Visits: (per person) First, Second and Third Visit Fourth and Fifth Visit Sixth Visit and After	 $300 Copay per visit $600 Copay per visit $900 Copay per visit If you are admitted, the Copay is waived; If non-emergency, 20% after Copay	 $300 Copay per visit $600 Copay per visit $900 Copay per visit If you are admitted, the Copay is waived; If non-emergency, 40% after Deductible
Ambulance (Ground or Air)	20% after Deductible	20% after Deductible
Inpatient Hospital Services including: Semi-private Room and Board Physician services Diagnostic / therapeutic lab and x-ray Drugs and medication Operating and recovery room Radiation therapy and chemotherapy Anesthesia and inhalation therapy	20% after Deductible *Except as otherwise provided for maternity care as explained in Section 8.2 below, Precertification/ Preauthorization required*	40% after Deductible *Except as otherwise provided for maternity care as explained in Section 8.2 below, Precertification/ Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*

Core PPO Option		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Outpatient Facility Services including: Operating room, recovery room, procedure room and treatment room, Physician services, Diagnostic/ therapeutic lab and x-rays, and anesthesia and inhalation therapy	20% after Deductible	40% after Deductible
Allergy Injections	$25/$75 Copay per visit	40% after Deductible
Routine Preventive Care, including: Immunizations, Associated x-ray and lab	No Charge, Deductible waived	NOT COVERED
Routine Preventive mammogram, Prostate-specific antigen (PSA), Pap Test, and Colorectal Screening	No Charge, Deductible waived	40% after Deductible
Women's Preventive Health Coverage: - FDA approved contraceptive and screening methods - Breastfeeding support/supplies/ counseling - Screening for domestic violence	100% covered Deductible Waived	40% after Deductible

Core PPO Option		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Colonoscopy and sigmoidoscopy (not subject to annual preventive maximum)	20% after Deductible (Physician's Charges covered at 100% for routine preventive)	40% after Deductible
Temporomandibular Joint Dysfunction (TMJ) non-surgical office visit only; excludes appliances and orthodontic treatment	20% after deductible	40% after Deductible
Laboratory and Radiology Services, including but not limited to: MRIs, MRAs, CAT scans, PET scans , bone scan, myelogram, ultrasound, and cardiac stress test	20% after Deductible	40% after Deductible
Other Health Care Facilities (Skilled Nursing Facility and Sub-Acute Facilities)	20% after Deductible *Preauthorization required for inpatient treatment*	40% after Deductible *Preauthorization required* for inpatient treatment
	60 days maximum per Plan Year combined[#]	
Home Health Care Services	20% after Deductible *Preauthorization required*	40% after Deductible *Preauthorization required*
	80 visits maximum per Plan Year combined[#]	
Hospice	20% after Deductible *Preauthorization required*	40% after Deductible *Preauthorization required*

[#] Combined benefits are the total of in-network and out-of-network benefits paid.

<table>
<tr><th colspan="3">Core PPO Option</th></tr>
<tr><th>Benefit Highlights</th><th><u>In-Network You Pay</u>:</th><th><u>Out-of-Network You Pay</u>:</th></tr>
<tr><td rowspan="2">Short-Term Rehabilitative Therapy including:

physical, speech & occupational therapy</td><td>$75 Copay per visit*</td><td>40% after Deductible</td></tr>
<tr><td colspan="2">60 visits/days maximum per Plan Year for all therapies combined#</td></tr>
<tr><td rowspan="2">Chiropractic Care</td><td>$75 Copay per visit*</td><td>40% after Deductible</td></tr>
<tr><td colspan="2">18 visits per calendar year maximum</td></tr>
<tr><td>Organ Transplants</td><td>20% after Deductible</td><td>40% after Deductible</td></tr>
<tr><td colspan="3">Organ Transplant Travel 20% after Deductible

$10,000 travel lifetime maximum. Eligible charges include: 1) Transportation to and from the transplant site; 2) lodging while at, or traveling to and from, the transplant site; and 3) food while at, or traveling to and from the transplant site. Travel expenses for companion(s) to accompany patient is also included. Eligible companion(s) include: a spouse, family member, legal guardian, or any person not related to the patient but actively involved as the patient's caregiver. Travel related benefits for organ transplants must be in compliance with IRS guidelines.

Eligible charges are covered at the in-network level, after deductible.</td></tr>
<tr><td>Durable Medical Equipment</td><td>20% after Deductible</td><td>40% after Deductible</td></tr>
<tr><td>External Prostheses</td><td>20% after Deductible</td><td>40% after Deductible</td></tr>
<tr><td>Family Planning Office Visit</td><td>$25/$75 Copay per visit*</td><td>40% after Deductible</td></tr>
</table>

* Deductible and applicable Coinsurance applies when x-ray and lab are processed by a separate provider.

Combined benefits are the total of in-network and out-of-network benefits paid.

Core PPO Option		
Benefit Highlights	**In-Network You Pay:**	**Out-of-Network You Pay:**
Maternity Care Physician's Services	$25/$75 initial visit Copay*, 20% (no Deductible) for all subsequent visits and 20% coinsurance after deductible for delivery *Except as otherwise provided for maternity care as explained in Section 8.2 below, Inpatient Preauthorization required*	40% after Deductible *Except as otherwise provided for maternity care as explained in Section 8.2 below, Inpatient Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*
Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excludes reversals)	20% after Deductible; *Inpatient Preauthorization required; Office surgery included in office visit Copay*	40% after Deductible *Inpatient Preauthorization required*
Infertility services (excludes in-vitro fertilization, artificial insemination, GIFT, ZIFT, etc.)	$25/$75 Copay per visit*, 20% after Deductible for treatment/surgery[1] *Inpatient Preauthorization required*	40% after Deductible *Inpatient Preauthorization required*
Abortion (non-elective only)	20% after Deductible	40% after Deductible
Mental Health Inpatient	20% after Deductible *Inpatient Preauthorization required*	40% after Deductible *Inpatient Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*

Core PPO Option		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Mental Health Outpatient	$25 Copay per visit*	40% after Deductible
Substance Abuse Inpatient	20% after Deductible *Inpatient Preauthorization required*	40% after Deductible *Inpatient Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*
Substance Abuse Outpatient	$25 Copay per visit*	40% after Deductible
All Other Covered Expenses	20% after Deductible	40% after Deductible

* Deductible and applicable Coinsurance applies when x-ray and lab are processed by a separate provider.

4.1.2 No Deductible PPO Option

No Deductible PPO Option		
Benefit Highlights	**<u>In-Network You Pay:</u>**	**<u>Out-of-Network You Pay:</u>**
Annual Deductible	n/a	$2,000 Individual $4,000 Family
Annual Out-of-Pocket Maximum	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family

* Deductible and applicable Coinsurance applies when x-ray and lab are processed by a separate provider.

No Deductible PPO Option		
Benefit Highlights	**In-Network You Pay:**	**Out-of-Network You Pay:**
Prescription Drug Annual Out-of-Pocket Maximum	$3,000 Individual $6,000 Family	
Lifetime Maximum Benefit	Unlimited	
Primary Office Visit (including Virtual Visits)	$30 Copay per visit*	30% after Deductible
Specialist Office Visit (including Virtual Visits)	$80 Copay per visit*	30% after Deductible
Urgent Care Facility	$80 Copay per visit	30% after Deductible
Hospital Emergency Room Number of Visits: (per person) First, Second and Third Visit Fourth and Fifth Visit Sixth Visit and After	$500 Copay per day $600 Copay per day $900 Copay per day	$500 Copay per day $600 Copay per day $900 Copay per day
	Copay is waived, if admitted	Copay is waived if admitted; if non-emergency, 30% after Deductible
Ambulance (Ground or Air)	$250 Copay per day	$250 Copay per day

* Deductible and applicable Coinsurance applies when x-ray and lab are processed by a separate provider.

No Deductible PPO Option		
Benefit Highlights	**<u>In-Network You Pay:</u>**	**<u>Out-of-Network You Pay:</u>**
Inpatient Hospital Services including: Semi-private Room and Board Physician services Diagnostic / therapeutic lab and x-ray Drugs and medication Operating and recovery room Radiation therapy and chemotherapy Anesthesia and inhalation therapy	$1,500 Copay per admission *Except as otherwise provided for maternity care as explained in Section 8.2 below, Preauthorization required.*	30% after Deductible *Except as otherwise provided for maternity care as explained in Section 8.2 below, Preauthorization required.* *$750 penalty if services are not preauthorized Out-of-Network*
Outpatient Facility Services including: Operating room, recovery room, procedure room and treatment room, Physician services, Diagnostic / therapeutic lab and x-rays, and anesthesia and inhalation therapy	$500 Copay per visit	30% after Deductible
Allergy Injections	$30 Copay per visit if a Primary Office Visit (or actual charge, if less) $80 Copay per visit if a Specialist Office Visit (or actual charge, if less)	30% after Deductible

No Deductible PPO Option		
Benefit Highlights	**In-Network You Pay:**	**Out-of-Network You Pay:**
Routine Preventive Care, including: Immunizations, Associated x-ray and lab	No Charge, Deductible waived	NOT COVERED
Routine Preventive mammogram, PSA, Pap Test, and Colorectal Screening	No Charge, Deductible waived	30% after Deductible
Women's Preventive Health Coverage: - FDA approved contraceptive and screening methods - Breastfeeding support/supplies/counseling - Screening for domestic violence	No Charge, Deductible waived	30% after Deductible
Colonoscopy and sigmoidoscopy (not subject to annual preventive maximum)	$500 Copay per visit (Physician's Charges covered at 100% for routine preventive)	30% after Deductible
Temporomandibular Joint Dysfunction (TMJ) non-surgical office visit only; excludes appliances and orthodontic treatment	$30 Copay per visit* if Primary Office Visit $80 Copay per visit* if Specialist Office Visit	30% after Deductible

* Deductible and applicable Coinsurance applies when x-ray and lab are processed by a separate provider.

No Deductible PPO Option		
Benefit Highlights	**In-Network You Pay:**	**Out-of-Network You Pay:**
Laboratory and Radiology Services, including but not limited to: MRIs, MRAs, CAT scans, PET scans, bone scan, myelogram, ultrasound, and cardiac stress test	$250 Copay per visit	30% after Deductible
Other Health Care Facilities (Skilled Nursing Facility and Sub-Acute Facilities)	$1,500 Copay per Admission *Preauthorization required for inpatient treatment*	30% after Deductible *Preauthorization required for inpatient treatment*
	60 days maximum per Plan Year combined[#]	
Home Health Care Services	$1,500 Copay per Admission *Preauthorization required*	30% after Deductible *Preauthorization required*
	80 visits maximum per Plan Year combined#	
Hospice	$1,500 Copay per Admission *Preauthorization required*	30% after Deductible *Preauthorization required*
Short-Term Rehabilitative Therapy: physical, speech & occupational therapy	$30 Copay per visit[*] if Primary Office Visit $80 Copay per visit if Specialist Office Visit	30% after Deductible
	60 visits / days maximum per Plan Year for all therapies combined	

[#] Combined benefits are the total of in-network and out-of-network benefits paid.

[*] Deductible and applicable Coinsurance applies when x-ray and lab are processed by a separate provider.

<table>
<tr><th colspan="3">No Deductible PPO Option</th></tr>
<tr><th>Benefit Highlights</th><th><u>In-Network You Pay:</u></th><th><u>Out-of-Network You Pay:</u></th></tr>
<tr><td rowspan="2">Chiropractic Care</td><td>$80 Copay per visit*</td><td>30% after Deductible</td></tr>
<tr><td colspan="2">18 visits per calendar year maximum</td></tr>
<tr><td>Organ Transplants</td><td>$1,500 Copay per Admission</td><td>30% after Deductible</td></tr>
<tr><td colspan="3">Organ Transplant Travel 0%, no Deductible

$10,000 travel lifetime maximum. Eligible charges include: 1) Transportation to and from the transplant site; 2) lodging while at, or traveling to and from, the transplant site; and 3) food while at, or traveling to and from the transplant site. Travel expenses for companion(s) to accompany patient is also included. Eligible companion(s) include: a spouse, family member, legal guardian, or any person not related to the patient but actively involved as the patient's caregiver. Travel related benefits for organ transplants must be in compliance with IRS guidelines.

Eligible charges are covered at the in-network level, after deductible.</td></tr>
<tr><td>Durable Medical Equipment</td><td>$250 Copay</td><td>30% after Deductible</td></tr>
<tr><td>Family Planning Office Visit</td><td>$30 Copay per visit* if Primary Office Visit

$80 Copay per visit* if Specialist Office Visit</td><td>30% after Deductible</td></tr>
<tr><td>Maternity Care Physician's Services</td><td>$30 Copay per initial visit* if Primary Office Visit

$1,500 Copay per Admission for delivery

Except as otherwise provided for maternity care as explained in Section 8.2 below, Inpatient Preauthorization required</td><td>30% after Deductible

Except as otherwise provided for maternity care as explained in Section 8.2 below, Inpatient Preauthorization required

$750 penalty if services are not preauthorized Out-of-Network</td></tr>
</table>

* Deductible and applicable Coinsurance applies when x-ray and lab are processed by a separate provider.

No Deductible PPO Option		
Benefit Highlights	**<u>In-Network You Pay:</u>**	**<u>Out-of-Network You Pay:</u>**
Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excludes reversals)	$1,500 Copay per Admission for Inpatient *Inpatient Preauthorization required; Office surgery included in office visit Copay of $30 Copay per visit if Primary Office Visit* *$80 Copay per visit if Specialist Office Visit*	30% after Deductible *Inpatient Preauthorization required*
Infertility services (excludes in-vitro fertilization, artificial insemination, GIFT, ZIFT, etc.)	Paid at applicable Copay (office visit, specialist visit, Outpatient or Inpatient) *Inpatient Preauthorization required*	30% after Deductible; *Inpatient Preauthorization required*
Abortion (non-elective only)	Paid at applicable Copay (office visit, specialist visit, Outpatient or Inpatient)	30% after Deductible
Mental Health Inpatient	$1,500 per admission *Inpatient Preauthorization required*	30% after Deductible *Inpatient Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*
Mental Health Outpatient	$30 Copay per visit if a Primary Office Visit $80 Copay per visit if a Specialist Office Visit $500 copay per day for outpatient services	30% after Deductible

No Deductible PPO Option		
Benefit Highlights	**<u>In-Network You Pay:</u>**	**<u>Out-of-Network You Pay:</u>**
Substance Abuse Inpatient	$1,500 per admission *Inpatient Preauthorization required*	30% after Deductible *Inpatient precertification/ Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*
Substance Abuse Outpatient	$30 Copay per visit if a Primary Office Visit $80 Copay per visit if a Specialist Office Visit $500 copay per day for outpatient services	30% after Deductible
ALL OTHER COVERED EXPENSES	100% Covered	30% after Deductible

4.1.3 High Deductible Health Plan (HDHP)

High Deductible Health Plan (HDHP)		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Calendar Year Deductible		
Teammate Only	$2,000	$4,000
Teammate + Spouse	$4,000	$8,000
Teammate + Children	$4,000	$8,000
Teammate + Family	$4,000	$8,000
(Includes medical and pharmacy)		

High Deductible Health Plan (HDHP)		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Lifetime Plan Maximum (includes Prescription Drug coverage)	Unlimited	
Out of Pocket Maximum Teammate Only Teammate + Spouse Teammate + Children Teammate + Family (Includes Deductible)	 $3,000 $6,000 $6,000 $6,000	 $6,000 $12,000 $12,000 $12,000
Primary Office Visit (including Virtual Visits)	20% after Deductible	40% after Deductible
Specialist Office Visit (including Virtual Visits)	20% after Deductible	40% after Deductible
Second Opinions	20% after Deductible	40% after Deductible
Urgent Care Facility	20% after Deductible	40% after Deductible
Hospital Emergency Room	20% after Deductible	20% after Deductible; if non-emergency, 40% after Deductible
Ambulance (Ground or Air)	20% after Deductible	20% after Deductible

High Deductible Health Plan (HDHP)		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Inpatient Hospital Services including: Semi-private Room and Board Physician services Diagnostic / therapeutic lab and x-ray Drugs and medication Operating and recovery room Radiation therapy and chemotherapy Anesthesia and inhalation therapy	20% after Deductible *Except as otherwise provided for maternity care as explained in Section 8.2 below, Preauthorization required*	40% after Deductible *Except as otherwise provided for maternity care as explained in Section 8.2 below, Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*
Outpatient Facility Services including: Operating room, recovery room, procedure room and treatment room, Physician services, Diagnostic/therapeutic lab and x-rays, and anesthesia and inhalation therapy	20% after Deductible	40% after Deductible
Allergy Injections	20% after Deductible	40% after Deductible
Routine Preventive Care, including: Immunizations, Associated x-ray and lab	No Charge Deductible waived	NOT COVERED

High Deductible Health Plan (HDHP)		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Routine Preventive mammogram, PSA, Pap Test, and Colorectal Screening	No Charge, Deductible waived	40% after Deductible
Women's Preventive Health Coverage: - FDA approved contraceptive and screening methods - Breastfeeding support/supplies/counseling - Screening for domestic violence	No Charge, Deductible Waived	40% after Deductible
Colonoscopy and sigmoidoscopy	20% after Deductible (Physician's Charges covered at 100% for routine preventive)	40% after Deductible
Temporomandibular Joint Dysfunction (TMJ) non-surgical office visit only; excludes appliances and orthodontic treatment	20% after Deductible	40% after Deductible
Laboratory and Radiology Services, including but not limited to: MRIs, MRAs, CAT scans, PET scans , bone scan, myelogram, ultrasound, and cardiac stress test	20% after Deductible	40% after Deductible

High Deductible Health Plan (HDHP)		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Other Health Care Facilities (Skilled Nursing Facility and Sub-Acute Facilities)	20% after Deductible *Preauthorization required*	40% after Deductible *Preauthorization required*
	60 days maximum per Plan Year combined*	
Home Health Care Services	20% after Deductible *Preauthorization required*	40% after Deductible *Preauthorization required*
	80 visits maximum per Plan Year combined*	
Hospice	20% after Deductible *Preauthorization required*	40% after Deductible *Preauthorization required*
Short-Term Rehabilitative Therapy including: physical, speech & occupational therapy	20% after Deductible	40% after Deductible
	60 visits/days maximum per Plan Year for all therapies combined*	
Chiropractic Care	20% after Deductible	40% after Deductible
	18 visits per calendar year maximum	
Organ Transplants	20% after Deductible	40% after Deductible
Organ Transplant Travel	20% after Deductible	

* Combined benefits are the total of in-network and out-of-network benefits paid.

High Deductible Health Plan (HDHP)		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
\$10,000 travel lifetime maximum. Eligible charges include: 1) Transportation to and from the transplant site; 2) lodging while at, or traveling to and from, the transplant site; and 3) food while at, or traveling to and from the transplant site. Travel expenses for companion(s) to accompany patient is also included. Eligible companion(s) include: a spouse, family member, legal guardian, or any person not related to the patient but actively involved as the patient's caregiver. Travel related benefits for organ transplants must be in compliance with IRS guidelines. Eligible charges are covered at the in-network level, after deductible.		
Durable Medical Equipment	20% after Deductible	40% after Deductible
External Prostheses	20% after Deductible	40% after Deductible
Family Planning Office Visit	20% after Deductible	40% after Deductible
Maternity Care Physician's Services	20% after Deductible *Except as otherwise provided for maternity care as explained in Section 8.2 below, Inpatient Preauthorization required*	40% after Deductible *Except as otherwise provided for maternity care as explained in Section 8.2 below, Inpatient Preauthorization required* *\$750 penalty if services are not preauthorized Out-of-Network*
Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excludes reversals)	20% after Deductible *Inpatient Preauthorization required*	40% after Deductible *Inpatient Preauthorization required*
Infertility services (excludes in-vitro fertilization, artificial insemination, GIFT, ZIFT, etc.)	20% after Deductible *Inpatient Preauthorization required*	40% after Deductible *Inpatient Preauthorization required*

High Deductible Health Plan (HDHP)		
Benefit Highlights	**<u>In-Network You Pay</u>:**	**<u>Out-of-Network You Pay</u>:**
Abortion (non-elective only)	20% after Deductible	40% after Deductible
Mental Health Inpatient	20% after Deductible *Inpatient Preauthorization required*	40% after Deductible *Inpatient Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*
Mental Health Outpatient	20% after Deductible	40% after Deductible
Substance Abuse Inpatient	20% after Deductible *Inpatient Preauthorization required*	40% after Deductible *Inpatient Preauthorization required* *$750 penalty if services are not preauthorized Out-of-Network*
Substance Abuse Outpatient	20% after Deductible	40% after Deductible
All Other Covered Expenses	20% after Deductible	40% after Deductible

Note: Out-of-Network benefits are limited to Allowable Amounts for Covered Expenses.

Note: Out-of-Network benefits for Preventive Care are limited to routine mammograms, PSA tests, Pap smears and colorectal screenings.

An HSA is a tax-advantaged account in your name that eligible Teammates can set up to pay for qualified health expenses that they or their eligible Dependents incur, while covered under the High Deductible Health Plan option or another high deductible medical plan. HSA contributions:

- accumulate over time and could earn interest or investment earnings;
- are portable after employment; and
- can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

When you enroll in the High Deductible Health Plan option, you must timely and properly establish, and may contribute to, an HSA. To timely and properly establish an HSA, you must meet the requirements of the bank, trust company, or other financial institution chosen by you to set up your HSA. Notwithstanding any provision in this Plan to the contrary, if you fail to timely and properly establish an HSA in accordance with the time frames and procedures set forth by the custodian of the HSA (including, but not limited to the commonly known "US Patriot Act of 2001," as amended), (a) the HSA contributions made by you will be returned to you, (b) you will not be entitled to receive any HSA contributions for the Plan Year, (c) you will immediately forfeit all HSA contributions, if any, made by the Company on your behalf, (d) you will immediately cease participation in the High Deductible Health Plan option, without any further action on your part as determined by the Plan Administrator, and (e) your High Deductible Health Plan option coverage will be automatically transferred, as determined by the Plan Administrator, to the Core PPO option of the Plan at the same level of coverage previously elected under the High Deductible Health Plan option. Further, when your coverage is transferred, the applicable premium due for the Core PPO option will be deducted on a pre-tax basis from your pay as determined by the Plan Administrator.

In addition to being enrolled in the High Deductible Health Plan option, you must meet the following requirements to participate in an HSA:

- must not participate in the McLane Company, Inc. Medical Expense Reimbursement Plan (the "Health Care Flexible Spending Account Plan") or any other health coverage including coverage under a Spouse's health plan or health care flexible spending account (with certain limited exceptions such as dental and vision coverage);
- must not be enrolled in Medicare;
- must not be enrolled in any part of Tricare (Veterans); or
- must not be claimed as a dependent on another person's tax return.

As mentioned above, you may **not** participate in an HSA if you participate in any other health coverage except for the High Deductible Health Plan option with a few narrow exceptions. Therefore, if you elect coverage under another health plan (certain limited exceptions apply) including the Health Care Flexible Spending Account Plan, you cannot participate in an HSA. Please note that you may participate in the McLane Company, Inc. Limited Purpose Medical Expense Reimbursement Plan for HSA Participants.

Although the High Deductible Health Plan is part of the Company's benefit program, your HSA is **not** a benefit sponsored by the Company. You are responsible for properly setting up your own HSA with a bank or other financial institution of your choice. The Company does not control the funds in your HSA or impose any conditions or restrictions on those funds. You have total responsibility for your HSA. You should consult with a tax advisor if you have questions about setting up your HSA or need information regarding the tax consequences of establishing an HSA.

Depending upon the type of HSA that you decide to set up, you may be able to invest your funds in certain investments, but that depends upon the bank or trust company you choose. The money in your HSA is always yours even if you enroll in another health plan or terminate employment with the Company. This means that all funds in your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the administrator of the HSA for the Company.

The law allows you, the Company, as your employer, and other individuals to make contributions to your HSA up to a certain maximum amount permitted by law depending upon your coverage level. These maximum amounts may change in subsequent years. It is important to note that the applicable individual or family maximum applies to all contributions made to your HSA whether you make the contributions, the Company makes the contributions or anyone else contributes funds to your HSA. However, individuals who have attained age 55 by the end of the taxable year may be able to make additional catch up contributions. For 2020, the maximum catch up contribution is $1,000. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

For 2020, the Company will make pre-tax Company contributions to your HSA if you participate in the Company's High Deductible Health Plan. During subsequent Plan Years, the Company contribution will be discretionary. If you elect coverage under the High Deductible Health Plan in 2020, the Company will make a $250 contribution to your HSA. The Company contribution will be made in full on a paycheck in January. The Company contribution to your HSA is discretionary and can be changed in the future. All Teammates will be notified if any changes are made to the Company contribution to your HSA. You make pre-tax contributions to your HSA by payroll deduction under the Company's Flexible Benefit Plan up to the total maximum permitted by law. As explained above, all contributions made to your HSA including the Company's contribution, your pre-tax salary deferral contributions, and any contributions other individuals make to your HSA count toward the total maximum amount permitted by law. You may change your pre-tax salary deferral contributions to your HSA at any time. If you do not choose to change your HSA contribution amount, it will continue from year to year as long as you are enrolled in the High Deductible Health Plan.

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

Note that if your coverage under the High Deductible Health Plan terminates and you do not have coverage under another high deductible health plan, no further contributions may be made to the HSA.

If you enroll in your HSA after January 1 you will still be allowed to contribute the maximum amount set by federal regulations for that year. However, if you want to contribute the maximum amount for that year when enrolling within the year, you must remain enrolled in the High Deductible Health Plan or other high deductible health plan for 13 months. Otherwise, you will be subject to an additional tax of 10% (see Federal law

for current HSA rules and penalty information). This means that you must make a commitment to participate in the High Deductible Health Plan and the HSA for two years. Alternatively, if you enroll in your HSA after January 1, you can choose to pro-rate the maximum amount for the partial year so that you do not have to make a two-year commitment to participate in the High Deductible Health Plan and the HSA.

It is very important to note that amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year. (See Federal law for current HSA rules and penalty information.)

The funds in your HSA will be available to help you pay your or your eligible Dependents' out-of-pocket costs under the High Deductible Health Plan, including annual Deductibles, Copays and Coinsurance and Prescription Drugs. You may also use your HSA funds to pay for medical care that is not covered under the High Deductible Health Plan but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses." IRS Publication 502 lists eligible health expenses. (See Federal law for current HSA rules and penalty information.)

4.2 Prescription Drug Benefits (Rx)

All Medical Plan Options include Prescription Drug benefits provided through Express Scripts. When you enroll in any Medical Plan Option, you are automatically enrolled in Prescription Drug benefits.

You will receive a separate identification card for your Prescription Drug benefits in the mail at your home. Additional ID cards can be obtained by calling Express Scripts customer service at 1-855-315-6433 **or online at** http://www.Express-scripts.com.

There are two components to your Prescription Drug program – the Express Scripts Retail and Mail Order Service. Retail prescriptions (up to a 34-day supply) are used for any short-term medications, such as antibiotics. Mail Order prescriptions (a 90-day supply) are used for any long-term, maintenance medications. In either case, Express Scripts reviews high cost Prescription Drugs to ensure that these medications are being used as clinically intended and that the quantity of certain Prescription Drugs do not exceed the FDA approved dosing guidelines. In addition, if you are taking maintenance Prescription Drugs, Express Scripts may contact you to explain the importance of taking, and the dangers of not taking, these Prescription Drugs.

- New prescription drug dispensing guidelines will apply as follows:
  - Teammates prescribed a new drug therapy will be given their first 90-day supply in three parts to reduce waste and ensure that the Teammate can use the medication.

- Teammates prescribed specialty drugs will have the first month's prescription split into two parts to reduce waste and ensure that the Teammate can use the medication.

4.2.1 Prescription Drug Schedule of Benefits

A Copay or Coinsurance is applied to each covered Prescription Drug as stated in the Prescription Drug Schedule of Benefits. You must bring your Physician's prescription to an In-Network Pharmacy (defined below) and the Prescription Drug will be filled for the lesser of 34 days or the length of time prescribed by the Physician. Preauthorization is required for compounded Prescription Drugs costing over $300.

Prescription Drug Schedule of Benefits

	Retail Program	Mail Service Program
When to Use Your Benefit:	For immediate medicine needs or short-term medicines	For maintenance or long-term medicines
Where	You can use your prescription drug benefit at participating pharmacies nationwide. To locate an Express Scripts participating retail pharmacy in your area, go to http://www.Express-scripts.com or call Express Scripts at 1-855-315-6433.	Mail your original prescription along with the mail service order form to Express Scripts. Your medicines will be sent directly to your home.
High Deductible Health Plan Participants must meet the combined medical and pharmacy Deductible before plan benefits begin. Benefits begin for all other PPO plan options upon the Participant's effective date.		

	Retail Program	Mail Service Program
In-Network Pharmacies		
Cost to You:	RETAIL • $5 Copay for each generic medicine • 30% Coinsurance for each brand name medicine on the National Preferred Formulary List for McLane Company (minimum $30 up to maximum of $60 Coinsurance) • 40% Coinsurance for each brand name medicine not on the National Preferred Formulary List for McLane Company (minimum $60 up to maximum of $120 Coinsurance) • 50% on lifestyle medicine	MAIL ORDER • $10 Copay for each generic medicine • $60 Copay for each brand name medicine on the National Preferred Formulary List for McLane Company $90 Copay for each brand name medicine not on the National Preferred Formulary List for McLane Company • 50% on lifestyle medicine

<table>
<tr><th></th><th>Retail Program</th><th>Mail Service Program</th></tr>
<tr><td colspan="3">Out-of-Network Pharmacies</td></tr>
<tr><td>Cost to You</td><td>RETAIL

• $5 Copay for each generic medicine

• 30% Coinsurance for each brand name medicine on the National Preferred Formulary List for McLane Company (minimum $30 up to maximum of $60 Coinsurance)

• 40% Coinsurance for each brand name medicine not on the National Preferred Formulary List for McLane Company (minimum $60 up to maximum of $120 Coinsurance)

• 50% on lifestyle medicine

You pay 100% of the cost of all Prescription Drugs obtained at Out-of-Network Pharmacies and then are required to file a paper claim.</td><td>MAIL ORDER

Not Covered</td></tr>
<tr><td></td><td colspan="2">High Deductible Health Plan Participants must meet the combined medical and pharmacy Deductible before prescription Copays benefits begin. Copays apply to all other Medical Plan Options upon the Participant’s effective date.

For the Core PPO Option and No Deductible PPO option, there is an RX Out-of-Pocket Maximum: $3,000 / Individual and $6,000 / Family. This Out-of-Pocket Maximum is separate from and is not integrated with the Medical Out-of-Pocket Maximum.</td></tr>
<tr><td>Women’s Preventive Coverage</td><td colspan="2">Certain generic and single source brand name drugs are covered at 100%. For more details, call Express Scripts at 1-855-315-6433 or visit www.Express-scripts.com.</td></tr>
</table>

	Retail Program	Mail Service Program
Day Supply Limit:	RETAIL 34- day supply *1-34 day supply= 1 Copay or applicable Coinsurance* *35-68 day supply= 2 Copays or applicable Coinsurance with 2x minimum/maximum* *69-90 day supply= 3 Copays or applicable Coinsurance with 3x minimum/maximum*	MAIL ORDER 90- day supply *1-90 day supply= 2 Copays*
Refill Limit:	RETAIL None	MAIL ORDER None
Web Services:	Register at http://www.Express-scripts.com to access tools that can help you save money and manage your prescription benefit. To register, have your benefit ID card handy.	
Express Scripts No.:	**Call 1-855-315-6433 or visit** http://www.Express-scripts.com	

4.2.2 In-Network Pharmacy Option

If you obtain your Prescription Drugs from a retail pharmacy, it is important that you use an In- Network Pharmacy. "In-Network Pharmacies" are pharmacies that have contracted with the pharmacy Claims Administrator under the Plan to provide Prescription Drugs to Participants at a predetermined cost. A list of In-Network Pharmacies is available online. If you would like to request a list of In-Network Pharmacies, please call Express Scripts at 1-855-315-6433.

4.2.3 Out-of-Network Pharmacy Option

Prescription Drugs may also be obtained from Out-of-Network Pharmacies. "Out-of-Network Pharmacies" are pharmacies that do **not** have a contract with the pharmacy Claims Administrator under the Plan to provide Prescription Drugs to Participants at a predetermined cost. If you obtain a Prescription Drug from an Out-of-Network Pharmacy, you will pay 100% of the cost of the Prescription Drug at the time it is obtained. *Please*

note that Prescription Drugs filled by a mail order Out-of-Network Pharmacy are not eligible for reimbursement. You should then submit a paper claim form, along with the detailed original prescription receipt(s) to Express Scripts for reimbursement of Covered Expenses at:

Express Scripts
Attn: Commercial Claims
PO Box 14711
St. Louis, MO 63121
Or fax your claim form to: 608.741.5475

Some important things to remember when submitting paper claims for reimbursement:

- You may print a claim form from the http://www.Express-scripts.com website or MyMcLane.
- Make sure to include your name, ID number, and date of birth with receipts.
- Make sure to include a correct mailing address where the check can be mailed.
- Include a photocopy of your Prescription Drug card, if possible. If a photocopy is not an option, please include the bin # and group # from the card.
- Include the receipts from the pharmacy that include drug name, Rx number, quantity, strength, National Drug Code (NDC) Number, and pharmacy location. A register receipt alone will not be sufficient.

Your claim will be processed and you will be furnished with an Explanation of Benefits (EOB). You will be reimbursed for any eligible Prescription Drug cost less any applicable Copay/Coinsurance, provided such Prescription Drugs are not excluded under the Prescription Drug benefits.

4.2.4 Mail Service Program

The Express Scripts Mail Service Program is a cost-effective choice for your long-term/maintenance medicines, **since you will be able to receive up to a 90-day supply for a Copay that is less than] you would pay for the same amount at retail**. Please note, however, if you obtain your 90 day Prescription Drug at Walgreens, you may receive a larger discount. You are not required to obtain your Prescription Drugs from Walgreens.

For new maintenance medicines, ask your Physician to write two prescriptions:

- One for up to a 30-day supply, to be filled immediately at an Express Scripts In-Network Pharmacy for use until you receive your Prescription Drug order from Express Scripts.

- The other, for up to a 90-day supply, plus any appropriate refills. This is for your order through the Express Scripts Mail Service Program. **Please note that if you are prescribed a new Prescription Drug therapy, you will receive your first 90 day supply in three parts to reduce waste and ensure that you can use the medication**.

Complete an **Express Scripts Mail Service Order Form** (available at http://www.Express-scripts.com) and send it to Express Scripts, along with your original prescription(s) and the appropriate Copay for each Prescription Drug. **Be sure to include your original prescription, not a photocopy.**

You must mail in an Express Scripts Mail Service Order Form each time you request a new Prescription Drug through the Express Scripts Mail Service Program. The automated service at 1-855-315-6433 and http://www.Express-scripts.com **is not available to you until we process your first prescription order.**

While Express Scripts prefers payment by credit card, you can also make payment by check or money order. For credit card payments, simply include your Visa®, Discover®, MasterCard®, or American Express® number and expiration date in the space provided on the **Express Scripts Mail Service Order Form**.

You should generally receive your Prescription Drugs approximately 10 to 14 calendar days after Express Scripts receives your order.

4.2.5 Contacting Your Physician Regarding Your Prescription

In certain situations, the review of your Prescription Drug may include a consult with your Physician. Express Scripts works with your Physician to provide him or her with information on the latest medical guidelines and therapy for your medical condition. The Express Scripts pharmacist may ask your Physician if an equally effective and less costly medicine is appropriate for you. This conversation between the pharmacist and your Physician could result in your Physician changing the prescribed medicine. Some possible examples are listed below.

4.2.6 Generic and Preferred Brand Name (Formulary) Medicines

If there is a generic or preferred brand name alternative available for your prescription, Express Scripts may substitute a generic medicine or contact your Physician to request authorization to change to a preferred brand name alternative. If your Physician has indicated "no substitution" on your prescription, your medicine cannot be changed without your Physician's permission.

4.2.7 Prescriptions Not Filled

In rare cases, the prescription your Physician wrote may be returned. If the Express Scripts pharmacist is unable to read your prescription or has questions about the medication, possible prescription interaction or dosing, and is unable to contact your Physician after several attempts, your prescription may be returned to you.

4.2.8 National Preferred Formulary List for McLane Company

The National Preferred Formulary List for McLane Company is a list of preferred brand name medicines generally considered to be more cost-effective and offer equal or greater therapeutic value than the other medicines in the same drug category. Physicians and pharmacists from a wide range of medical specialties review and approve the brand name medicines on the National Preferred Formulary List for McLane Company. These Physicians and pharmacists conduct rigorous clinical analysis to evaluate and select each National Preferred Formulary medicine for safety and efficacy.

You should give your Physician a copy of the National Preferred Formulary List for McLane Company on your next visit. If the Physician prescribes a medicine in any of the categories listed on the National Preferred Formulary List, check with your Physician to find out if the preferred medicine can be utilized whenever appropriate. This list does not guarantee coverage. The medicine must still be an allowable item under the prescription benefit plan.

The cost of medicines varies widely, even though there may be several different medicines available to treat the same condition. Generic medicines offer the most savings and therefore, have the lowest Copay. Brand name medicines are much more expensive, and often there are many brands at various cost levels available to treat the same condition.

Express Scripts has one National Preferred Formulary List, which is used for both mail and retail.

Medicines not on the National Preferred Formulary List for McLane Company may still be covered under the Prescription Drug program; however, you may be required to pay a higher Copay or Coinsurance.

When modifications are made, Participants will be notified if they have filled prescriptions for medicines deleted from the National Preferred Formulary List for McLane Company over the last six months. Participants will be sent a letter from Express Scripts explaining the change in their National Preferred Formulary List medicine status and informing them that there will be changes in their Copays or Coinsurance. Participants will also receive a personalized listing of the medicines they are currently receiving that have been removed from the National Preferred Formulary List for McLane Company and the appropriate category identifying an alternative listed on the National Preferred Formulary List for McLane Company. Consult with your Physician to determine if the identified generic or National Preferred Formulary List for McLane Company alternative is appropriate for you.

The National Preferred Formulary List for McLane Company is periodically updated. Medicines may be deleted if they become available generically, receive over-the-counter (OTC) approval, are discontinued by the manufacturer, have other National Preferred Formulary List for McLane Company alternatives that continue to meet needs, or can be replaced with clinically similar alternatives that provide a more favorable cost advantage. In general, Express Scripts makes formulary changes twice a year. However, the formulary list is updated in real time online. For the most up-to-date National Preferred Formulary

List for McLane Company, visit the Express Scripts Web site at https://www.express-scripts.com/2021drugs. The complete list of exclusions (including updated information) and preferred alternatives are available online at this Web site.

4.2.9 Lifestyle Drugs

Lifestyle Drugs include some drugs in the following classifications: Fertility drugs, Diet Medications, Renova (used to treat wrinkles, brown spots, etc.), Retin-A (used to treat acne), Smoking Cessation including Chantix, Erectile Dysfunction, Hair Loss, Prozac Weekly, Differin (used to treat acne), Avita (Vit. A to treat acne), Vaniqa (used to treat removal of unwanted facial hair in women) and Accutane (used to treat acne).

Contact Express Scripts Customer Care if you have questions about Lifestyle Drugs or to determine drug coverage and exclusions at 1-855-315-6433 or visit www.Express-scripts.com.

4.2.10 Generic Conversion Program

The Plan encourages the use of generic Prescription Drugs whenever your provider feels it will be an acceptable form of treatment. When filling a Prescription Drug for a brand name drug that has a generic drug equivalent available, you will be offered the generic drug. If you decline to use the generic drug, you will be required to pay the Copay/Coinsurance for the brand name drug, plus the difference in the cost of the ingredients between the brand name Prescription Drug and generic Prescription Drug.

Your provider does have the option to indicate in writing on your prescription that the generic alternative of the Prescription Drug is NOT acceptable by writing Dispense As Written (DAW). In this instance, you would be required to pay the brand name drug Copay/Coinsurance only.

4.2.11 Specialty Drug Program

Express Scripts Specialty Pharmacy Services is a mandatory program designed for the conditions listed below and is subject to change. This benefit offers convenient delivery of your specialty medicines, personalized service and educational support for your specific therapy. Using Express Scripts Specialty Pharmacy Services is easy and convenient. Express Scripts will assign a team of professionals to help manage your daily needs, provide 24-hour access to a clinical pharmacist for consultation at no additional cost to you, and deliver treatments directly to your home or office, or pick up at certain retail locations. If you are prescribed specialty drugs, your first month's prescription will be split into two parts to reduce waste and ensure that you can use the medication.

Express Scripts offers Specialty Pharmacy Services for:

- Asthma
- Crohn's Disease

- Gaucher's Disease
- Growth Hormone Deficiency
- Hematopoietics
- Hemophilia, von Willebrand
- Hepatitis C
- Hormonal Therapies
- Immune Disorders
- Multiple Sclerosis
- Oncology
- Osteoarthritis
- Osteoporosis
- Psoriasis Disease and related bleeding
- Pulmonary Hypertension disorders
- Rheumatoid Arthritis
- RSV Prevention

To take advantage of these benefits and continue to receive coverage for your specialty medicines, you will need to transfer your prescription to Express Scripts Specialty Pharmacy Services. To transfer your prescription, please call Accredo (a subsidiary of Express Scripts) at 1-800-922-8279 and identify yourself as a Participant in the Plan (client code **MCLANRX)**. For your convenience, Express Scripts will call your Physician and take care of the appropriate paperwork. Express Scripts will also follow-up with a phone call to answer any questions and assist with your transition.

The Core PPO option, the No Deductible Plan option, and the Out-of-Network option have a Copay assistance program known as SaveonSP. **SaveonSP is not available to Participants in the High Deductible Health Plan option**. This Copay assistance program helps members coordinate manufacturer-sponsored Copay assistance for certain specialty drugs. SaveonSP targets 100+ drugs in many of the top specialty categories, including multiple sclerosis, oncology and hepatitis C.

You must be enrolled in SaveonSP to participate in this program. You may be contacted directly by SaveonSP to enroll, or your pharmacy may require prior approval before filling

the prescription and guide you to speak to SaveonSP. If you are eligible and don't enroll, you may pay a higher Copay and this higher payment may not count toward your Deductible or your Out-of-Pocket Maximums under the Plan. You may contact Express Scripts at 1-855-315-6433 to find out if a Prescription Drug you take is eligible for this program.

4.2.12 Step Therapy Program

The Prescription Drug program includes a step therapy program which requires Participants to try a generic or lower cost drug first before a name brand drug or higher cost drug may be used. A name brand drug or higher cost drug will only be approved if the generic or lower cost drug does not work. As indicated above, if you are prescribed a new Prescription Drug therapy, you will be given your first 90- day supply in three parts to reduce waste and ensure that you can use the medication.

4.2.13 Prior Authorization

To receive benefits, certain medications must be reviewed and approved by Express Scripts to ensure the appropriateness of care. A list of the Prescription Drugs that require prior authorization is available on the Express Scripts website at www.express-scripts.com. You may also contact Express Scripts Customer Care at 1-855-315-6433 for more information.

4.2.14 Prescription Drug Exclusions

Some excluded Prescription Drug items may be covered by your medical benefits.

Drugs excluded from the Pharmacy and Mail Order Prescription Drug Benefit options are the following:

1. Over-the-counter drugs except Insulin and test strips
2. Therapeutic devices (ex: back brace, knee brace, etc.) or support garments and other non-medical substances
3. Drugs intended for use in a Physician's office or settings other than home use
4. Biological sera, blood or blood plasma
5. Allergy extracts/serums
6. Glucose Monitors
7. Rogaine
8. Dietary supplements, prescription supplements and vitamins with and without fluoride (except for pre-natal vitamins)
9. Hemantinics – Immune Disorders (ex: blood plasma)

10. Ostomy supplies (bags and pouches)

11. Needles, alcohol wipes and IV prep

12. Prescriptions related to Workers' Compensation injuries or illness

13. Drugs which are not Medically Necessary, including any drugs given in connection with a service or supply which is not Medically Necessary, but excluding Lifestyle Drugs listed above

14. Drugs or shots to prevent disease or allergies

15. Drugs taken at the same time and place where the prescription is ordered

16. Charges for giving or injecting drugs

17. Drugs given while Confined in a Hospital, nursing home or similar place that has its own dispensary

18. Any refill that is made more than one year after the latest prescription was written

19. Any refill that is more than the number of refills ordered by the Physician

20. Contraceptive Devices, except Nuvaring and Orthoevera (ex: diaphragms & IUDs)

21. Contraceptive Kits (ex: Preven, "the morning after" pill.)

22. Respiratory Therapy Devices (ex: Nebulizers & Aerochambers)

23. Toxoids (used in immunizations)

24. Vaccines

25. Drugs which are dispensed at a Nursing Home or outside of the United States

26. Cosmetic products (not including acne medications or hair growth stimulants) such as: depigmenting agents, hair removal agents, and Botox

27. Infant formula or nutritional supplements unless needed due to a genetic condition present at birth

28. Compound drugs that do not contain a Prescription Drug component

29. Chantix

30. Marijuana of any kind including medicinal or recreational marijuana in any form including edible and smokeable forms

4.2.15 Pharmacy Appeals

Pharmacy appeals – See "When You Have a Complaint or Appeal" section.

Pharmacy appeals should be directed to:

Express Scripts Customer Care at 1-855-315-6433

All first and second level pharmacy appeals that **do not** involve a determination of medical necessity should be directed to:

Express Scripts.
P. O. Box 66587
St. Louis, MO 63166-6587
Attn: Administrative Appeals Department
Telephone No. 1-800-946-3979

All first and second level pharmacy appeals that **do** involve a determination of medical necessity should be directed to:

Express Scripts.
P. O. Box 66587
St. Louis, MO 63166-6588
Attn: Clinical Appeals Department
Telephone No. 1-800-753-2851

4.2.16 Certain Preventive Care Drugs and Drug Copay Reduction Requests

The following preventive care drugs/services will be covered by McLane at 100% if the required guidelines are met which include, but are not limited to, having a prescription from a Physician when an item from this list is purchased over the counter. Please note that exclusions and quantity limitations apply to the list below. Please call Express Scripts at 1-314-996-0900 to obtain the full list of requirements.

- Aspirin
- Folic Acid
- Iron Supplements
- Fluoride Supplements
- Vaccines
- Tobacco Cessation (excludes Chantix)

- Vitamin D

In addition, you may request that the Copay be reduced or waived for certain drugs, as required under PPACA, where the generic would be considered medically inappropriate. Please call Express Scripts at 1-855-315-6433 to obtain the full list of requirements.

4.3 Covered Expenses

The term Covered Expenses means the Expenses Incurred by or on behalf of a Participant for the Charges listed below, if they are incurred after he/she becomes covered for benefits. Expenses incurred for such Charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary and are determined by the Claims Administrator to be Allowable Amounts. Any applicable Copays, Coinsurance, Deductibles or Maximums are shown in the applicable Schedule of Benefits.

This section generally explains the medical benefits that are available under the Medical Plan Options. Please remember to refer to **DEFINITIONS** for a description of terms. If you have a question about the covered services listed below, please call the customer service department at 1-866-363-7936.

If you choose a ***Participating Provider***, the provider will bill the Claims Administrator - not you - for services provided. The provider has agreed to accept as payment in full the least of:

- The billed Charges,
- The Allowable Amount as determined by the Claims Administrator, or
- Other contractually determined payment amounts, and
- Deductibles, Copay Amounts, and Co-Insurance Amounts you are responsible for paying.

You may be required to pay for limited or noncovered services. No claim forms are required.

If you choose ***Non-Participating Providers***, only Out-of-Network Benefits will be available.

If you go to a provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose an Out-of-Network provider, you may have to submit claims for the services provided. You will be responsible for:

- Billed Charges above the Allowable Amount,
- Copay and Co-Insurance Amounts,

- Deductibles, and
- Limited or noncovered services.

You will also be responsible for obtaining preauthorization of the services.

4.3.1 Provider Professional Services

- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse for professional nursing service.

4.3.2 Virtual Visits

Charges made by a Participating Provider for professional services rendered during a Virtual Visit. Virtual Visits are not covered Out-of-Network. Virtual Visits are offered under all Medical Plan Options including the High Deductible Health Plan option. Participating Providers can diagnose and treat a wide range of non-emergency medical conditions. Examples of conditions commonly treated are bladder infections, diarrhea, rash, urinary tract infections, fever, sinus infections, bronchitis, migraine headaches, sore throat, cold, flu, pink eye and stomach. You can ask your Participating Provider if Virtual Visits are available or you can go to https://www.bcbstx.com/mclane or call customer service at 1-866-363-7936 to find the most current listing of Participating Providers who offer Virtual Visits.

If you participate in the Core PPO Plan option or the No Deductible Plan option, you will be charged the same Copay for Virtual Visits that apply for in-person office visits. For the High Deductible Health Plan option, you must satisfy your Deductible before the Plan will begin paying benefits for Virtual Visits.

4.3.3 Ambulance

Charges for licensed ambulance (ground or air) services to or from the nearest Hospital where the needed medical care and treatment can be provided.

4.3.4 Hospital Emergency Room/Emergency Care

The Medical Plan Options provide coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficulty breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries, burns and poisonings.

If reasonably possible, contact your Network Physician before going to the Hospital emergency room. Your Physician can help you determine if you need Emergency Care and recommend that care. If not reasonably possible to contact your Physician, go to the nearest emergency facility, whether the facility is in the Network. Any applicable Copays, Coinsurance, Deductibles or Maximums are shown in the applicable Schedule of Benefits.

Whether you require hospitalization (Hospital Confinement) or not, you should notify your Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so your Physician can recommend the continuation of any necessary medical services. Expenses Incurred for such Charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary and do not exceed the Allowable Amount, as determined by the Claims Administrator. Any applicable Copays, Coinsurance, Deductibles or Maximums are shown in the applicable Schedule of Benefits.

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In-Network Benefits. After 48 hours, In-Network Benefits will be available only if you use Participating Providers. If, after the first 48 hours of treatment following the onset of a medical emergency and if you can safely be transferred to the care of a Participating Provider but are treated by a Non-Participating Provider, only Out-of-Network Benefits will be available.

In-Network and Out-of-Network Benefits for Covered Expenses will be determined on the same basis as for treatment of any other Sickness. Copay amounts will be required for facility Charges for each outpatient Hospital emergency room visit as indicated on your Schedule of Benefits. If you are admitted for the emergency condition immediately following the visit, the Copay amount will be waived. Preauthorization of the inpatient admission will be required.

Benefits for Covered Expenses incurred for the continued treatment of an accidental Injury will be considered on the same basis as for treatment of any other Sickness.

If treatment is given in an Emergency Room for a condition that a prudent layperson, possessing an average knowledge of medicine and health, would not believe that the person's condition, Sickness, or Injury is of such a nature that failure to get immediate care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus;

then this care would only be eligible for non-emergency benefits per the Schedule of Benefits.

4.3.5 Inpatient Hospital Services

Among those expenses normally included under inpatient Hospital services for a Hospital Admission/Confinement are intensive and coronary care units, operating room, lab and x-ray, and blood. Please note that if you are confined in a private room, only the Hospital's average semiprivate room rate is reimbursable for Inpatient Hospital Confinement.

Covered Services will not include that portion of Charges for Room and Board that is more than the Hospital Room and Board daily limits shown in the Covered Expense Daily Limits section. Remember that each Hospital Admission requires Preauthorization (1-800-441-9188).

In-Network: In-Network means you receive covered services or benefits from Participating Providers. The percentage of your total eligible inpatient Hospital services in excess of any Deductible shown under "Inpatient Hospital Services" on the Schedule of Benefits for In-Network benefits is your obligation to pay. The remaining total eligible Inpatient Hospital Services in excess of any Deductible is the Medical Plan Option's obligation to pay. The Participant's Coinsurance amount will be applied to the In-Network Out-of-Pocket Maximum (HDHP Participant's Deductible also applies to the In-Network Out-of-Pocket Maximum).

Out-of-Network: Out-of-Network means you receive covered services or benefits from providers who are not Participating Providers. The percentage of your total eligible inpatient Hospital Services in excess of any Deductible shown under "Inpatient Hospital Services" on the Schedule of Benefits for Out-of-Network benefits is your obligation to pay as well as any amounts over the Allowable Amount. The remaining eligible unpaid Allowable Amount for inpatient Hospital Services in excess of any Deductible is the Medical Plan Option's obligation to pay. The Participant's Coinsurance amount will be applied to the In-Network and Out-of-Network Out-of-Pocket Maximums. (Under the HDHP, the Participant's Deductible also applies to the In-Network Out-of-Pocket Maximum).

Covered services and supplies provided by a Non-Participating Provider will receive In-Network Benefits when those services and supplies are not available from a Participating Provider within 75 miles of your home but you must call the number on the back of your ID card to obtain authorization for Non-Participating Provider coverage. Your request may or may not be approved. If you obtain authorization for services provided by a Non-Participating Provider, benefits for those services will be covered at the Participating Provider benefit level. Failure to obtain authorization and approval will result in those services being covered at a Non-Participating Provider level.

4.3.6 Outpatient Facility Services

- Charges made by a Hospital, on its own behalf, for medical care and treatment you receive as an outpatient.

- Charges made by a Free-Standing Surgical Facility, on its own behalf, for medical care and treatment.

- Charges made by an Other Health Care Facility, including a Skilled Nursing Facility, a rehabilitation Hospital or a sub-acute facility on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion of such otherwise Covered Expenses in excess of the Other Health Care Facility Daily Limit shown in the Covered Expense Daily Limits section, nor will benefits be payable for more than the maximum number of days shown in the Schedule of Benefits.

4.3.7 Routine Preventive Care

Benefits for Preventive Care services will be determined as indicated on your Schedule of Benefits for Physician office visits, Diagnostic lab, and x-rays. Benefits are not available for inpatient Hospital expense for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child. Injections for allergies are not considered immunizations under this benefit provision. The following are examples of Preventive Care services that are covered, but Preventive Care services may change:

- Charges made by a Participating Provider for routine Preventive Care, not to exceed any maximum shown in the Schedule of Benefits. Routine Preventive Care means well-child care, health care assessments, wellness visits, immunizations, and any related services.

- Hearing Impairment benefits:

    - For a screening test for hearing loss from birth through the date the child is 30 days old; and

    - Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months.

- Childhood Immunizations include diphtheria, Haemophilus influenzae type b, hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella, and any other immunization that is required by law for the child.

- Charges made for a mammogram for women age 35 to 69, every 1 to 2 years, or at any age for women at risk, when recommended by a Physician.

- Charges made for an annual Papanicolaou laboratory screening test (Pap test).

- Charges made for an annual prostate-specific antigen test (PSA) and digital rectal exam.

As part of the Preventive Care services, the Plan offers the Livongo Diabetes Management program and the Livongo Hypertension program under all Medical Plan Options.

Under the Livongo Diabetes Management Program, you will be provided with a connected glucose meter that transmits blood glucose readings to you and, at your option, to your family members as well as doctors. This allows you to know instantly when your blood glucose readings are out of range. You also receive coaching from certified diabetes educators that are available 24 hours a day, 7 days per week and 365 days per year to answer diabetes questions about nutrition, lifestyle changes, and diabetes management. Additionally, your glucose readings may be reported to a BCBSTX clinician so that glucose readings and trends can be discussed with the clinician. Finally, test strips and lancets are delivered to your home at no extra cost.

Under the Livongo Hypertension program, you will be provided with a connected blood pressure cuff that transmits your readings to a Livongo coach. You will be provided with tailored reminders, personalized recommendations, and live coaching.

If you would like to participate in the Livongo Diabetes Management program or the Livongo Hypertension program or would like additional information on either program, please contact Livongo at 1-800-945-4355. You may also sign up for either of these programs by going to the following website: join.livongo.com/MCLANE-HCSC/begin.

4.3.8 TMJ

- Charges made for non-surgical care for TMJ and related care, which includes care for:

  (a) Temporomandibular Joint and Craniomandibular Joint Disorders; and

  (b) other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves and other tissues related to that joint.

- This does not include dental work, such as, but not limited to, orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or equilibrations, whether done for dental or medical reasons. Coverage is subject to the maximum shown in the Schedule of Benefits.

4.3.9 Laboratory and Radiology Services

Charges made for anesthetics and their administration; Diagnostic x-ray and laboratory examinations; x-ray, radium and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and the administration of the same; prosthetic appliances; and dressings.

Deductible and applicable Coinsurance applies as shown in the Schedule of Benefits when x-ray and lab are processed by a separate provider.

4.3.10 Other Health Care Facilities – Skilled Nursing Facility

- All usual nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);

- Room and board and all routine services, supplies and equipment provided by the Skilled Nursing Facility;

- Physical, occupational, speech and respiratory therapy services by licensed therapists.

Preauthorization is required (1-800-441-9188).

4.3.11 Home Health Care Services

Charges made for Home Health Care Services when you:

- require skilled care, from:

    - Part-time or intermittent nursing care by an R.N. or by an L.V.N.;

    - Part-time or intermittent Home Health Aide services which consist primarily of caring for the patient;

- are unable to obtain the required care as an ambulatory outpatient; and

- do not require confinement in a Hospital or Other Health Care Facility.

Home Health Care Services are provided under the terms of a Home Health Care Plan for the person named in that plan and are subject to the Home Health Care Benefit Maximum shown in the Schedule of Benefits.

Benefits will not be provided for Home Health Care Services for the following:

- Food or home delivered meals;

- Social case work or homemaker services;

- Custodial Services provided primarily for Custodial Care;

- Transportation services;

- Home Infusion Therapy;

- Durable medical equipment.

Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under “Short-term Rehabilitative Therapy.”

Preauthorization is required (1-800-441-9188).

4.3.12 Hospice Care Services

Charges made due to Terminal Illness for the following Hospice Care Services provided under a Hospice Care Program:

- by a Hospice Facility for Room and Board and Necessary Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of Charges which is more than the Hospice Room and Board Limit shown in the Covered Expense Daily Limits section;

- by a Hospice Facility for services provided on an out-patient basis;

- by a Physician for professional services;

- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within 1 year after the person's death;

- for pain relief treatment, including drugs, medicines and medical supplies;

- by an Other Health Care Facility for:

    - part-time or intermittent nursing care by or under the supervision of a Nurse;

    - part-time or intermittent services of an Other Health Care Professional;

    - physical, occupational and speech therapy; and

    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such Charges would have been payable under the Medical Plan Option if the person had remained or been Confined in a Hospital or Hospice Facility.

The following Charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;

- for any period when you are or your Dependent is not under the care of a Physician;

- for Necessary Services or Supplies not listed in the Hospice Care Program;

- for any curative or life-prolonging procedures;

- to the extent that any other benefits are payable for those expenses under the Medical Plan Option;

- for services or supplies that are primarily to aid you or your Dependent in daily living.

Preauthorization is required (1-800-441-9188)

4.3.13 Short-Term Rehabilitative Therapy

Charges made for Short-Term Rehabilitative Therapy that is a part of a rehabilitation program, including physical, speech, occupational, cardiac and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting.

The following limitations apply to Short-Term Rehabilitative Therapy Services:

- Occupational therapy is provided only for purposes of training the individual to perform the activities of daily living.

- Speech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered Custodial Care or educational; or (c) intended to maintain speech communication.

Benefits for all Short-Term Rehabilitative Therapies, whether under the In-Network or Out-of-Network benefit level, will be combined in a Plan Year and will not exceed the Benefit Maximum shown in the Schedule of Benefits.

4.3.14 Chiropractic Care

Charges made for Chiropractic Care or services as follows:

- Charges for care are limited to the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function;

- Charges for office examinations including: patient history; physical examination; spinal x-rays; laboratory tests; and neuromuscular treatment and manipulation;

- Charges for lab work;

- Charges are limited to Medically Necessary care provided in an office setting.

Excluding any Charges for:

- Services of a Chiropractor which are not within the scope of his practice, as defined by state law;

- Maintenance Treatment or Preventive Care;

- Chiropractic Care in excess of the Benefit Maximum shown in the Schedule of Benefits.

All payments made by the Medical Plan Option for Chiropractic Care, whether under the In-Network or Out-of-Network Benefit level, will apply toward the benefit maximum under all levels of benefits.

4.3.15 Organ Transplant Services

Subject to the conditions described below, benefits for covered services and supplies provided to a Participant (donor and/or recipient) by a Hospital, Physician, or other provider related to an organ or tissue transplant will be determined as follows, but only if:

1. The transplant procedure is not Experimental/Investigational in nature;

2. Donated human organs or tissue are used;

3. The recipient is a Participant under the Medical Plan Option (benefits are also available to the donor who is a Participant under the Medical Plan Option);

4. The transplant procedure is preauthorized as provided below;

5. The Participant meets all of the criteria established by the Claims Administrator (details provided upon request); and

6. The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory, chemotherapy, radiation therapy, and complications arising from such transplant.

Benefits are available and will be determined on the same basis as any other Sickness when the transplant procedure is for the following:

- Liver
- Heart
- Heart - Lung (heart and 1 lung or heart and both lungs)
- Kidney
- Cornea
- Lung
- Bone Marrow

Covered services and supplies include services and supplies provided for the:

1. Evaluation of organs or tissues including, but not limited to, the determination of tissue matches;

2. Removal of organs or tissues from deceased donors or coverage for live donor; and

3. Transportation and storage of donated organs or tissues.

No benefits are available for a Participant for the following services or supplies:

1. Living and/or travel expenses of the live donor or recipient except as specified below;

2. Donor search and acceptability testing of potential living donors;

3. Expenses related to maintenance of life for purposes of organ or tissue donation; and

4. Purchase of the organ or tissue.

Preauthorization is required for any organ or tissue transplant and is the process by which the Medical Necessity of the transplant and the length of stay of the admission is approved or denied.

Preauthorization does not guarantee payment of a claim but does ensure that payment for the covered Room and Board Charges for the preauthorized length of stay will not be denied on the basis of Medical Necessity.

At the time of Preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary.

No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such procedure) which the Claims Administrator considers to be Experimental/Investigational.

Organ Transplant Travel Services

Charges made for reasonable travel Expenses Incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. The travel benefit is applicable if there is not an In-Network facility providing the necessary transplant service where the member lives. The member and a caregiver may submit expenses for lodging and travel per the Schedule of Benefits.

Benefits for transportation, lodging and food are available to you and your caregiver only if you are the recipient of a pre-approved organ/tissue transplant. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles

of your home; laundry bills; telephone bills; alcohol or tobacco products; and Charges for transportation that exceed coach class rates.

These benefits are only available when the Participant is the recipient of an organ transplant. Travel benefits are limited to $10,000 maximum per Participant.

4.3.16 Durable Medical Equipment

Charges made for the purchase or rental of Durable Medical Equipment that is ordered or prescribed by a provider and provided by a vendor approved by the Claims Administrator. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than 1 person, primarily and customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to: crutches, hospital beds, wheel chairs, insulin pumps, respirators, and dialysis machines.

Unless covered in connection with the services described in another section of this SPD, the following are specifically excluded:

- Hygienic or self-help items or equipment;
- Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
- Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
- Institutional equipment, such as air fluidized beds and diathermy machines;
- Elastic stockings and wigs;
- Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;
- Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
- Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.

4.3.17 Prosthetics

Charges made for the initial purchase and fitting of external prosthetic devices that are used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of conditions caused by an Injury or Sickness, or congenital defect. External prosthetic appliances shall include artificial arms and legs and terminal devices such as hands or hooks. Replacement of external prosthetic appliances is covered when necessitated by normal anatomical growth or wear and tear.

4.3.18 Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery following a mastectomy, if you choose to have surgery, and in the manner chosen by you and your Physician. Services and benefits include:

- surgical services for reconstruction of the breast on which surgery was performed;
- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- postoperative breast prostheses; and
- mastectomy bras and external prosthetic limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered. In all instances, coverage will comply with the 1998 Women's Health & Cancer Rights Act.

4.3.19 Maternity Care

Services and supplies incurred by you for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Medical Plan Options as listed on the Schedule of Benefits. Pregnancy benefits cover all related expenses from the initial Physician visit to confirm pregnancy through the Hospital Charges for the delivery of the baby. The Medical Plan Options provide coverage for inpatient care for the mother and newborn child in a health care facility (such as a Hospital or Birthing Center) for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

Preplanned home deliveries are not covered.

Benefits are available for Medically Necessary care provided by an appropriately licensed and certified Midwife under the direct supervision of a Physician acting within the scope of his / her license, subject to the exclusion for home births above.

In-Network Physician expenses for the mother's pre-natal care and delivery are contracted with the Claims Administrator for a flat amount. Thereafter, the Deductible and Coinsurance will apply.

In-Network Example:

- ***Initial Physician visit to confirm pregnancy – office visit Copay only (Core & No Deductible Plan)***

- ***Subsequent pre-natal Physician visits – Annual Deductible and Coinsurance apply (Core & HDHP)***

- ***Physician Charges associated with delivery – Annual Deductible and Coinsurance apply (Core & HDHP)***

- ***Hospital Charges for the mother's care – Annual Deductible and Coinsurance apply (Core & HDHP)***

- ***Hospital Charges for the infant's care –Annual Deductible and Coinsurance apply (Core & HDHP) (only if infant is added to coverage)***

- ***Inpatient admission for delivery for the mother's care – Inpatient Copay (per admission) Copay only (No Deductible Plan)***

- ***Inpatient admission for delivery for the infant's care – Inpatient Copay (per admission) Copay only (No Deductible Plan) (only if infant is added to coverage)***

All pregnancy-related Out-of-Network expenses are subject to the Plan Year Deductible and applicable Coinsurance. Claims will be paid according to the Allowable Amount; Charges above this amount are your responsibility.

4.3.20 Family Planning

Covered Expenses include:

- Charges for Family Planning services, including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other medical services, information and counseling on contraception; and implanted/injected contraceptives and contraceptive devices such as: Norplant, IUDs, administration of Depo Provera shot.

- Charges made for medical services connected with surgical therapies (vasectomy and tubal ligation), excluding procedures to reverse sterilization.

4.3.21 Infertility Services

Charges made by a Participating Provider for services related to the diagnosis of infertility

and treatment of infertility once a condition of infertility has been diagnosed.

Infertility Services include approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy. Remember that any Hospital Admission requires Preauthorization (1-800-441-9188).

The following infertility services (which is not exhaustive) are specifically excluded:

- infertility drugs;
- gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), artificial insemination (AI) and variations of these procedures;
- any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees);
- a reversal of voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- cryopreservation of donor sperm and eggs; and
- any Experimental/Investigational infertility procedures or therapies.

4.3.22 Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, Covered Expenses made for the treatment of any physiological conditions related to Mental Health will not be considered to be Charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, Charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be Charges made for treatment of Substance Abuse.

4.3.22.1 Inpatient Mental Health Services

Inpatient Mental Health Services are services provided when you are Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization, and Mental Health Residential Treatment Services. **Each Admission requires Preauthorization (1-800-528-7264).**

Mental Health Residential Treatment Services are services provided by a Hospital that are designated by the applicable Claims Administrator for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health

conditions. You are considered Confined in a Residential Treatment Center when you are a registered bed patient in a Residential Treatment Center upon the recommendation of a Physician. **Each Admission requires Preauthorization (1-800-528-7264).**

Mental Health Residential Treatment Center means an institution that (a) specializes in the treatment of psychological and social disturbances that are the result of mental health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a Residential Treatment Center.

Partial Hospitalization means a therapeutic program that provides less than 24 hour care (usually during the day) for mental health patients in transition from full-time inpatient care to outpatient care and a return to the community.

4.3.22.2 Outpatient Mental Health Services

Outpatient Mental Health Services are services of providers who are qualified to treat mental health:

- when treatment is provided on an outpatient basis, and
- you are not Confined in a Hospital or Residential Treatment Center, as defined in Section 4.3.21.1, and
- when treatment is in an individual, group or structured group therapy program.

Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

4.3.22.3 Inpatient Substance Abuse Rehabilitation Services

Inpatient Substance Abuse Rehabilitation Services are services provided for rehabilitation, when you are Confined in a Hospital for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Residential, Partial Hospitalization, and Substance Abuse Intensive Outpatient Therapy Programs. **Each Admission requires Preauthorization (1-800-528-7264)**.

Substance Abuse Residential Treatment Services are services provided by a Hospital that is designated by the applicable Claims Administrator for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions. You are considered Confined in a Residential Treatment Center when

you are a registered bed patient in a Residential Treatment Center upon the recommendation of a Physician. **Each Admission requires Preauthorization (1-800-528-7264).**

Substance Abuse Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which you live in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a Residential Treatment Center.

4.3.22.4 Substance Abuse Intensive Outpatient Therapy

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient structured therapy programs provide a combination of individual, family and/or group therapy in a day, totaling 9 or more hours in a week. Outpatient Substance Abuse Rehabilitation Services are services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you are not Confined in a Hospital, including outpatient rehabilitation in an individual, group, structured group.

4.3.22.5 Substance Abuse Detoxification Services

Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Claims Administrator will determine if Medical Plan Options are available based on the Medical Necessity of each situation, and if so, whether on an inpatient or outpatient basis. Each Admission requires Preauthorization (1-800-528-7264).

4.3.22.6 Exclusions

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under the Medical Plan Options.

- Treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.

- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.

- Counseling for activities of an educational nature.

- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial Care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.
- Any benefits in excess of any specified maximum number of days or visits.

Other limitations are shown in the "Expenses Not Covered/Exclusions" section.

4.3.23 Cosmetic Surgery

The Plan may cover eligible Charges made for Cosmetic Surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw), tumors, trauma, disease or the complications of Medically Necessary, non-Cosmetic Surgery.

Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by the Claims Administrator.

Treatment provided for the correction of defects incurred in an accidental Injury sustained by you, but only if treatment is sought within 24 hours of the accidental Injury.

4.4 Case Management

Case Management is a service provided through the Claims Administrator, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with you, your family and the attending Physician regarding the appropriate treatment options which will best meet your needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also

available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are R.Ns. and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on treatment programs and medical technology. While the Case Manager may recommend alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

1. You, your Dependent or an attending Physician can request Case Management services. In addition, the Company, a claim office or a utilization review program may refer an individual for Case Management.

2. The Claims Administrator assesses each case to determine whether Case Management is appropriate.

3. If your case is selected, you or your Dependent will be contacted by an assigned Case Manager who will explain in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

4. Following an initial assessment, the Case Manager will work with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available. (For example, in-home medical care in lieu of an extended Hospital convalescence.) You are not penalized if the alternate treatment program is not followed.

5. The Case Manager arranges for alternate treatment, and Necessary Services and Supplies, as needed. (For example, nursing services or a Hospital bed and other Durable Medical Equipment for the home.)

6. The Case Manager also acts as a liaison between you, your family and your Physician as needed. (For example, by helping you to understand a complex medical diagnosis or treatment plan.)

7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to your needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

4.5 Additional Programs

4.5.1 Women's and Family Health Program

Prenatal education, regular obstetric check-ups, and lifestyle awareness are key factors in helping pregnant women deliver healthy babies. The Women's and Family Health Program provides prenatal risk assessment education and coordinates with your Physician to provide case management services to help reduce the chance of low birth-weight infants and/or premature delivery.

If you are pregnant, you must enroll beginning in your 1st trimester. A confidential assessment helps determine if your pregnancy is at risk.

You will be assisted by an obstetrical Nurse with questions and concerns in the areas of:

- Assessing your health and lifestyle factors,
- Discussing prenatal care,
- Providing education relevant to your risk factor(s),
- Helping your Physician develop a treatment plan and alternatives, and
- Encouraging the use of other resources, as appropriate.

5. CLAIMS

5.1 How to File Your Claim

When you or your Dependents seek medical care through a Participating Provider, you are only responsible for the applicable Copay, Coinsurance or Deductible amount shown in the Schedule of Benefits. You do not need to file a claim form.

If you or your Dependents seek medical care through a Non-Participating (Out-of-Network) Provider, you must submit a claim form to be reimbursed.

All claims for benefits under the Medical Plan Options must be properly submitted within 90 days of the date you receive the services or supplies. Claims not submitted and received by the Claims Administrator within 12 months after that date will not be considered for payment of benefits except in the absence of legal capacity.

You may get the required claim forms from your local Human Resources Department or online. Go to https://www.bcbstx.com/mclane/member-resources, print the medical claim form, complete all sections, make a copy, include receipts and mail it to the BCBSTX address at the top of the form. Depending on your Medical Plan Options, file your claim forms as described below.

5.1.1 Hospital Confinement/Hospital Admission

If possible, get your group medical insurance claim form before you are admitted to the Hospital. This form may make your admission easier and any cash deposit usually required may be waived.

If you have your applicable ID card, present it at the admission office at the time of your admission. The card tells the Hospital to send its bills directly to the Claims Administrator.

5.1.2 Physicians' Bills and Other Medical Expenses

The first medical claim should be filed as soon as you have incurred a medical expense. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

5.1.3 Claim Reminders

- BE SURE TO USE YOUR UNIQUE ID NUMBER AND GROUP NUMBER (McLane Core & No Deductible Plans: 090271, McCarty Hull Core & No Deductible Plans: 091000, MBM Core and No Deductible Plans: 090271, McLane HDHP: 090281, McCarty Hull HDHP: 091001, MBM HDHP: 090281) WHEN YOU FILE YOUR CLAIM FORMS, OR WHEN YOU CALL YOUR CLAIMS ADMINISTRATOR'S OFFICE.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

- IN MOST CASES PROVIDERS WILL FILE THE NECESSARY CLAIM FORMS, HOWEVER, IT IS YOUR RESPONSIBILITY TO ENSURE CLAIMS HAVE BEEN FILED TIMELY.

Please note that your Unique ID Number is used in place of your social security number as your plan identification number. Each Claims Administrator issues unique ID numbers to you. The Company does not have access to these numbers because they are created by the Claims Administrators. Providers will need your unique ID number to properly file claims on your behalf. Please present your ID card each time you receive services to ensure that providers have the correct billing information on file for you.

WARNING: Fraudulent claims cause you to pay more each year, as the cost to pay claims increases overall. If you knowingly present a false or fraudulent claim for payment of a loss or benefit, you are guilty of a crime and may be subject to fines and confinement in prison. If you commit fraud or make an intentional misrepresentation of a material fact to obtain coverage under the Plan, you and your beneficiary's coverage under the Plan will be terminated retroactively back to the date that the fraud was committed or the intentional misrepresentation of a material fact was made and criminal charges may be pursued to reimburse the Plan for fraudulent claims.

5.2 Cost to You

You are required to pay a contribution toward the cost of your coverage. The amount of the required contribution amount will be provided to you in your enrollment materials, and the contribution for your elected coverage will be deducted from your pay on a pre-tax basis. You will be notified in advance of any change in your cost of coverage. In addition, certain Deductibles, Coinsurance and Copays apply. Please refer to your Schedule of Benefits. You may also see the current list of rates for your coverage tier available at your local Human Resources Department.

It is also important to note that the Medical Plan Options require an extra pre-tax premium ("Spouse Premium") in the amount of $125.00 per pay check to cover your Spouse if he/she is eligible for coverage under another group medical plan. If you elect to cover your Spouse, you must pay the Spouse Premium if your Spouse is eligible to be covered under another group medical plan. For purposes of this Spouse Premium, Medicare, Medicaid and TriCare will not be considered as another group medical plan.

If your Spouse is employed, but is not eligible for coverage under another group medical plan, this Spouse Premium will not apply. However, if your Spouse later becomes eligible for coverage under another group medical plan, this Spouse Premium will apply at that time if you decide to continue your Spouse's coverage under a Medical Plan Option under this Plan. It is your responsibility to notify your local Human Resources Department within 60 days of any change in your Spouse's eligibility for another group medical plan.

The Company has instituted this premium in an effort to control its rising healthcare costs and to encourage employees of other employers to be covered under their own employer's medical plans, when possible.

5.3 Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Group Plan and determines how benefits payable from all such Group Plans will be coordinated. You should file all claims with each Group Plan.

The Medical Plan Options under this Plan require information regarding other group health insurance coverage for you and any of your eligible Dependents. The Company and/or the Claims Administrator will periodically request other insurance information from you. This request may or may not occur in connection with a submitted claim. If so, you will be advised that the other insurance information (including an explanation of benefits from the other insurance carrier) is required before the submitted claim will be processed for payment. If no response is received within 90 days, the claim will be denied. If the requested information is subsequently received by the Claims Administrator, the claim will be processed according to the Schedule of Benefits.

Coverage under a Medical Plan Option of this Plan plus another plan is not a guarantee of 100% total reimbursement.

5.3.1 Definitions

For the purposes of this section, the following terms have the meanings set forth below:

5.3.1.1 Group Plan

Any of the following that provide benefits or services for medical care or treatment:

1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public nor is individually underwritten, including closed panel coverage.

2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.

3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Group Plan or part of a Group Plan which has the right to coordinate benefits will be considered a separate Group Plan.

5.3.1.2 Primary Plan

The Group Plan that determines and provides or pays benefits without taking into consideration the existence of any other Group Plan.

5.3.1.3 Secondary Plan

A Secondary Plan is a Group Plan that may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you or request reimbursement from you.

5.3.1.4 Reasonable Cash Value

A Reasonable Cash Value is an amount which a duly licensed provider of health care services usually Charges patients and which is within the range of fees usually charged for the same service if rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area where the health care service was delivered.

5.3.2 Order of Benefit Determination Rules

A Group Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Group Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1) The Group Plan that covers you as an enrollee or a Teammate shall be the Primary Plan and the Group Plan that covers you as a Dependent shall be the Secondary Plan;

2) For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Group Plan which covers the parent whose birthday falls first in the calendar year;

3) For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

   a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Group Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

   b) then, the Group Plan of the parent with custody of the child;

   c) then, the Group Plan of the Spouse of the parent with custody of the child;

   d) then, the Group Plan of the non-custodial parent of the child, and

   e) finally, the Group Plan of the Spouse of the parent not having custody of the child.

4) The Group Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Group Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Group Plan does not have a similar provision and, as a result, the Group Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

5) The Group Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Group Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Group Plan does not have a similar provision and, as a result, the Group Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

6) If one of the Group Plans that covers you determines the order of benefits based upon the gender of a parent, and as a result, the Group Plans do not agree on the order of benefit determination, the Group Plan with the gender rules shall determine the order of benefits.

If none of the above rules determine the order of benefits, the Group Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, the Medical Plan Options under this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Group Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

5.3.3 Effect on the Benefits of the Medical Plan Options

If the Medical Plan Option under this Plan is the Secondary Plan, the benefits that would be payable under the Medical Plan Option in the absence of coordination will be reduced by the benefits payable under all other Group Plans for the expense covered under the Medical Plan Option of this Plan.

When a Group Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an Expense Incurred and a benefit payable.

5.3.4 Recovery of Excess Benefits

If the Claims Administrator pays Charges for Necessary Services and Supplies that should have been paid by the Primary Plan, the Claims Administrator will have the right to recover such payments.

The Claims Administrator will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, healthcare plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

5.3.5 Right to Receive and Release Information

The Claims Administrator, without consent or notice to you, may obtain information from and release information to any other Group Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide the Claims Administrator with any information requested in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim. If so, you will be advised that the "other coverage" information, (including an Explanation of Benefits (EOB) paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

5.4 Right of Reimbursement

The Medical Plan Options under this Plan do not cover:

1) Expenses for which another party may be responsible as a result of liability for causing or contributing to the Injury or Sickness of you or your Dependent(s).

2) Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care expenses as described in (1) and (2) above, the Medical Plan Options under the Plan shall automatically have a first priority lien upon the proceeds of any recovery by you or your Dependents from such party to the extent of any benefits provided to you or your Dependents by the Medical Plan Options under the Plan whether or not the settlement or judgment specifically provides for the Medical Plan Options' recovery. You or your Dependent(s), or any representative thereof, shall execute such documents as may be required to secure the Plan's rights. The Medical Plan Options under the Plan shall be reimbursed the lesser of:

- the amount actually paid by the Claims Administrator under the Medical Plan Options; or

- an amount actually received from the third party, at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or otherwise.

5.5 Payment of Benefits

5.5.1 To Whom Payable

All medical benefits are payable to you. However, at the option of the Claims Administrator and with the consent of the Plan Administrator, all or any part of them may be paid directly to the person or institution on whose charge the claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of the Claims Administrator, 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, the Claims Administrator may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, the Claims Administrator may choose to make direct payment to any of your following living relatives: Spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release the Medical Plan Options under the Plan from all liability to the extent of any payment made.

5.5.2 Time of Payment

Benefits will be paid by the Claims Administrator when it receives due proof of loss.

5.5.3 Recovery of Overpayment

When an overpayment has been made by the Claims Administrator, the Claims Administrator will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

5.6 Claim Determination Procedures

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the applicable Medical Plan Options and the discretion to interpret and determine benefits and your eligibility for a benefit under the Plan in accordance with the Medical Plan Options' provisions. The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Plan and is responsible for determining whether any individual is eligible to participate in the Plan. Any powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly in a manner designed to assure similar treatment to persons in similar circumstances.

5.6.1 Claim Procedures / Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the Medical Plan Options. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "pre-service Medical Necessity determination." This SPD describes who is responsible for obtaining this review. You or your authorized representative (typically, your Physician) must request Medical Necessity determinations according to the procedures described below.

When services or benefits are determined not to be Medically Necessary, you or your representative will receive a written description of the Adverse Benefit Determination, and may appeal the determination. Appeal procedures are described below.

5.6.1.1 Pre-service Claim / Pre-service Medical Necessity Determinations

A Pre-Service Claim is when you or your representative request an initial required Medical Necessity determination prior to care. However, a pre-service Medical Necessity determination (Preauthorization/pre-admission certification) does not guarantee payment of benefits. **Coverage is always subject to other requirements of the Medical Plan Options, such as, limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.**

See section titled "Certification Requirements" for more information.

For non-urgent Pre-Service Claims, the Claims Administrator will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed because the Claims Administrator has both:

(i) determined that such extension is needed and beyond the Claims Administrator's control, and

(i) notifies you prior to the expiration of the initial 15 day period of the circumstances requiring the extension of time and the date the Claims Administrator expects to render a decision,

the claim determination time period may be extended once for up to 15 days. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, this is known as an "Urgent Care Claim." For Urgent Care Claims, the Claims Administrator will make the pre-service determination on an expedited basis. The Claims Administrator's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. The Claims Administrator will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Claims Administrator will notify you or your representative within 72 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to the Claims Administrator within 48 hours after receiving the notice. The Claims Administrator will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow the Claims Administrator's procedures for requesting a required pre-service Medical Necessity determination, the Claims Administrator will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 72 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

See "Appeals Procedure" section for information about filing an appeal on a Pre-Service claim determination.

5.6.1.2 Concurrent Medical Necessity Determinations

An ongoing course of treatment to be provided over a period of time or number of treatments is known as "Concurrent Care". When this has been approved for you and you wish to extend the approval for an Urgent Care Claim, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, the Claims Administrator will notify you or your representative of the determination within 24 hours after receiving the request. The Claims Administrator may notify you of its decision orally within the 24 hour time period described above; provided, however, that in the case of oral notification, the Claims Administrator shall provide written or electronic notification to you not later than 3 days after the oral notification. Otherwise, the Claims Administrator must notify you by written or electronic notification within the 24 hour time period described above. For Concurrent Care that is a non-Urgent Care Claim, the Claims Administrator will notify you of any reduction or termination of the care within a reasonable period of time before any such reduction of termination of such care takes place.

5.6.1.3 Post-Service Claim / Post-Service Medical Necessity Determinations

A Post-Service Claim is when you or your representative requests a Medical Necessity determination after services have been rendered. For Post-Service Claims, the Claims Administrator will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed because the Claims Administrator has both:

(i) determined that such extension is needed and beyond the Claims Administrator's control, and

(ii) notifies you prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date the Claims Administrator expects to render a decision,

the claim determination time period may be extended once for up to 15 days.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

See "Appeals Procedure" section for information about filing an appeal on a Post-Service claim determination.

All claims for benefits under the Plan should be properly submitted within 90 days of the date you receive the services or supplies. Claims not submitted and received by the Claims Administrator within 12 months after that date will not be considered for payment of benefits except in the absence of legal capacity.

5.6.1.4 Notice of Adverse Determination

Every notice of an Adverse Benefit Determination will be provided in writing and/or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Medical Plan Option's provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the Medical Plan Option's review procedures and the time limits applicable, including a statement of a your right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on appeal; (5) a description of any internal rule, guideline, protocol or other similar criterion (collectively "Protocols") that were relied upon in making the adverse determination regarding your claim, and that a copy of such Protocols will be available free of charge, upon your request; (6) 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 applying the terms of the Medical Plan Option, as applicable to your medical circumstances; and (7) in the case of an Urgent Care Claim, a description of the expedited review process applicable to such claim.

5.6.2 When You Have a Complaint or An 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.

BCBSTX wants you to be satisfied with the care you receive. Therefore, a process has been established for addressing your concerns and helping to solve your problems.

5.6.2.1 Start With Member Services

Member Services is here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit ID card, explanation of benefits or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

Member Services will do its best to resolve the matter on your initial contact. If the Claims Administrator needs more time to review or investigate your concern, they will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can begin the appeals procedure.

5.6.2.2 Internal Appeals Procedure

The Medical Plan Options under this Plan have one internal level of appeal for coverage decisions, except for claims involving eligibility to participate in the Plan. Once the internal level of appeal is exhausted for claims that do not involve eligibility, the Medical Plan Options have an external appeals procedure. Please refer to the External Appeals Procedure below for information on the external appeal for claims that do not involve eligibility. For eligibility claims, there are two internal levels of appeal reviewed by the Plan Administrator, but there is no external appeal for eligibility claims. Please see Subsections 5.6.2.3 and 5.6.2.4 for information on internal levels of appeal.

To initiate an internal appeal for claims other than eligibility, you must submit a request for an appeal in writing to the Claims Administrator within 180 days of receipt of the claim denial notice. The appeals address is the same as the address listed on your Explanation of Benefits. 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 the Claims Administrator to register your appeal by telephone. Call or write to us at the following toll-free number or address:

Claim Review Section
Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, Texas 75266-0044
Telephone No.: 1-866-363-7936 (TTY/TDD: 711)
Fax No: 1-888-235-2936

This information may also be found on your Explanation of Benefits or claim form.

To initiate an internal appeal for claims involving eligibility, you must submit a request for an appeal in writing to the Plan Administrator within 30 days after you have been notified that you are not eligible for coverage under the Plan. You should state the reason why you feel you are eligible to participate in the Plan and should include any information supporting your appeal.

For all internal appeals, you may inspect or request reasonable access to relevant information free of charge. You may also submit written comments, documents, records and other information for review of your claim.

5.6.2.3 Internal Level of Appeal

If you appeal a claim other than an eligibility claim, your appeal will be reviewed and the decision will be made by someone that was not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be evaluated by a health care professional.

For internal appeals other than eligibility, the Claims Administrator will respond in writing with a decision as follows:

- within 15 calendar days after an appeal is received for a required Pre-Service claim or Concurrent Care coverage determination, and

- within 30 calendar days after an appeal for a Post-Service claim / coverage determination is received.

If more time or information is needed to make the determination on an internal appeal that does not involve eligibility, the Claims Administrator will notify you in writing to request an extension of up to 15 calendar days and specify any additional information needed to complete the review.

You may request that the appeal process for claims other than eligibility be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing Hospital stay. The Claims Administrator's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. If an appeal is expedited, the Claims Administrator will respond orally with a decision within 72 hours, followed up in writing.

In the case of the first level of internal appeal for an eligibility claim, the Plan Administrator will generally respond in writing with a decision within 30 calendar days. The Plan Administrator may extend this 30-day time period if it needs more time to make a decision. In addition, the Plan Administrator may request that you provide additional information. If additional information is requested, the Plan Administrator will allow you additional time to provide the information.

If you are dissatisfied with the decision made in your internal level of appeal, you may be able to request a second review. A second internal level of appeal is available for eligibility claims. This second internal level of appeal is handled internally by the Plan Administrator. The second review for claims other than eligibility claims is an external level of appeal handled externally by an Independent Review Organization ("IRO"). However, only certain claims that do not involve eligibility are eligible for review by an IRO. Please refer to section 5.6.2.7 of the Standard External Review section for additional information on claims that are eligible for external review. You must notify the Plan Administrator in writing at the following address of your desire for a second review:

McLane Company, Inc.
Attn: BENEFITS MANAGER, HEALTH PLAN APPEALS
4747 McLane Parkway
Temple, Texas 76504

5.6.2.4 Second Internal Level of Appeal for Eligibility Claims

To initiate a second internal level of appeal for an eligibility claim, you must notify the Plan Administrator (at the address set forth in Subsection 5.6.2.3 above) that you want to appeal within 30 days after you receive notice from the Plan Administrator that your first internal level of appeal has been denied. **The Plan Administrator will review only those claims that involve questions of eligibility.**

The Plan Administrator will generally respond with a decision within 30 calendar days. The Plan Administrator may extend this 30-day time period if it needs more time to make a decision. In addition, the Plan Administrator may request that you provide additional information. If additional information is requested, the Plan Administrator may allow you additional time to provide the information.

5.6.2.5 Notice of Benefit Determination on Internal Appeal for Claims Other Than Eligibility Claims

Every notice of a determination or appeal for claims other than eligibility claims will be provided in writing and/or electronically by the determining party. If an adverse determination is rendered in the case of a claim other than an eligibility claim, it will include the following: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provision on which the determination is based; (3) 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; (4) 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); (5) a description of any Protocols that were relied upon in making the adverse determination regarding your appeal, and that a copy of such Protocols will be available, free of charge, upon your request; and (6) 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 applying the terms of the Medical Plan Option, as applicable, to the claimant's medical circumstances. 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.

5.6.2.6 Relevant Information

Relevant Information is any document, record, or other information which: (a) was relied upon in making the benefit determination; (b) 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; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

5.6.2.7 Standard External Review

1. Request for External Review. Once you have exhausted the internal appeal process (or been deemed to have exhausted the internal appeal process) for a claim that does not involve eligibility, you or your authorized representative may initiate an external review of your Adverse Benefit Determination by notifying the Plan Administrator (at the address set forth in Subsection 5.6.2.3 above). You must notify the Plan Administrator within four months after the date you receive notice of an Adverse Benefit Determination from the Claims Administrator that your internal level of appeal has been denied.

The Plan Administrator will forward all claims that do not involve questions of eligibility to an IRO and will notify you in writing that your request for external review has been received and has been forwarded to an IRO.

The external review process is only available for an Adverse Benefit Determination that involves medical judgement or the rescission of coverage. The external review process is not available for an appeal of an Adverse Benefit Determination involving eligibility. An Adverse Benefit Determination involving eligibility includes a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your beneficiary fails to meet the requirements for eligibility under the terms of the Plan.

The IRO is composed of persons who are not employed by the Claims Administrator or any of its affiliates or by the Plan Administrator or any of its affiliates. A decision to use this level of appeal will not affect your rights to any other benefits under the Medical Plan Options under the Plan.

The Claims Administrator, to the extent reasonably requested by the Plan Administrator, will provide information that it has in its possession to assist the IRO in making the external level of appeal determination.

2. Preliminary Review. Within five business days following the date of receipt of the external review request, the Plan Administrator must complete a preliminary review of the request to determine whether:

a. You are, or were, covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

b. The Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

c. You have exhausted the internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the Exhaustion section below for additional information and exhaustion of the internal appeal process; and

d. You or your authorized representative has provided all the information and forms required to process an external review.

You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, the Plan Administrator will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Plan Administrator will take action against bias and to ensure independence. Accordingly, the Plan must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits and the IRO may not impose any costs on the claimant requesting the review.

The IRO must provide the following:

a. Utilization of legal experts where appropriate to make coverage determinations under the Plan

b. Timely notification to you or your authorized representative, in writing, of the request and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

c. Within five business days after the date of assignment of the IRO, the Plan Administrator shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination. Failure by the Plan Administrator to timely provide the documents and information will not delay the conduct of the external review. If the Plan Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination. Within one business day after making the decision, the IRO will notify the Plan Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Plan Administrator and the Plan Administrator must promptly forward the information

to the Claims Administrator. Upon receipt of any such information, the Claims Administrator may reconsider the Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claims Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claims Administrator decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Claims Administrator will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Claims Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claims Administrator's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted to the Claims Administrator, you, or your treating Provider;

(4) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claims Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to the Plan Administrator, the Claims Administrator or you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Plan Administrator, Claims Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

4. Reversal of the Plan's Decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination, the Plan Administrator and Claims Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

5.6.2.8 Expedited External Review

1. Request for Expedited External Review. The Plan Administrator must allow you or your authorized representative to make a request for an expedited external review with the Plan Administrator at the time you receive:

a. An Adverse Benefit Determination, if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your

ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary Review. Immediately upon receipt of the request for expedited external review, the Plan Administrator will determine whether the request meets the reviewability requirements set forth in the Standard External Review section above. The Plan Administrator will send you a notice of its eligibility determination that meets the requirements set forth in Standard External Review section above.

3. Referral to IRO. Upon a determination that a request is eligible for external review following the preliminary review, the Plan Administrator will assign an IRO pursuant to the requirements set forth in the Standard External Review section above. The Plan Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Claims Administrator's internal claims and appeals process.

4. Notice of Final External Review Decision. The Plan Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the Standard External Review section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Plan Administrator and you or your authorized representative. The Plan Administrator will immediately forward the decision to the Claims Administrator.

5.6.2.9 Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the final internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine

whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claims Administrator waives the internal review process or the Claims Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claims Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

5.6.2.10 Legal Action

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. You may not initiate a legal action against the applicable Medical Plan Option until you have completed the appeal process or until you are deemed to have completed the appeal process. Once the appeal process has been exhausted or is deemed to be exhausted, you have one year from the date you are notified of a final Adverse Benefit Determination to file suit or initiate legal action against the Plan.

5.6.2.11 Anti-Assignment Provision

You may not assign, sale, transfer, pledge, or encumber any assets or benefits payable to you or anyone else under the Plan, except (a) as required by law, or (b) pursuant to a Qualified Medical Child Support Order. The Plan's assets or benefits are not subject to any charge, garnishment, execution, or levy of any kind, including your liability for alimony or other payments for support of your Spouse or former Spouse, or any of your other relatives. Any attempt by you or anyone else to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable under the Plan will be void.

The Plan's anti-assignment provision means that none of the benefits under this Plan payable to you, any other person, entity or third party, including to an out-of-network provider (or any representative or agent of a provider) are ever assignable or transferable to any other party or are subject to any lien by any person or party, either before or after benefits, services, or supplies are provided to you or any other person. The Claims Administrator/Plan Administrator reserves the sole right and discretion to make any benefit payments under the Plan directly to (a) you, (b) any Participating Provider, (c) any out-of-network provider/Non-Participating Provider, or (d) another designated person or entity. In such case, the benefit payment will be made on your behalf and not on behalf of the recipient and will not constitute a waiver of this anti-assignment provision. The Plan is not liable for, or subject to, any obligation or liability (e.g., through garnishment, attachment, pledge or bankruptcy) of yours or a third-party that you, the third party or anyone else may

be liable to for medical care, treatment or services but the Claims Administrator/ Plan Administrator may choose to comply with such requests. In addition, you (or anyone else) cannot assign to any health care provider your right to request Plan documents or to receive any penalty related to any delay or failure to provide documents or any claim related to a breach of fiduciary duty or to otherwise enforce ERISA.

You may appoint an authorized representative in writing to act on your behalf in accordance with procedures established by the Claims Administrator/ Plan Administrator and applicable law.

6. EXPENSES NOT COVERED / EXCLUSIONS

Covered Expenses will not include, and no payment will be made for, Expenses Incurred:

- for Charges for supplies, care, treatment or surgery which are not Medically Necessary and essential to the diagnosis, or direct care and treatment of a Sickness, Injury, condition, or bodily malfunction, or any Experimental / Investigational services and supplies, as determined by the Claims Administrator;

- to the extent that payment is unlawful where you reside when the expenses are incurred;

- for Charges which would not have been made if you had no coverage;

- to the extent that the Charges are more than the Allowable Amount as determined by the Claims Administrator;

- for or in connection with dental Surgical Procedures not covered under the Medical Plan Option;

- for an opinion obtained more than 3 months after a surgeon has first recommended the Elective Surgical Procedure;

- for an opinion rendered by the Physician who performs the Surgical Procedure;

- for any services or supplies provided in connection with an occupational Sickness or an Injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law;

- for any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality except as required by Medicare and Medicaid; provided, however, that this exclusion shall not be applicable to any coverage held by you for Hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;

- for or in connection with Cosmetic Surgery or therapy, unless coverage is otherwise provided under the "Covered Expenses" section of this SPD;

- for eyeglasses, contact lenses, hearing aids or examinations for prescription or fitting thereof; however, Covered Expenses will include purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery;

- for or in connection with treatment of the teeth or peridontium, unless such expenses are incurred for: (a) Charges made for a continuous dental treatment started within 6 months of an Injury to sound natural teeth; (b) Charges made by a Hospital for Room and Board or Necessary Services and Supplies; or (c) Charges made by the outpatient department of a Hospital in connection with surgery;

- for or in connection with surgical treatment for temporomandibular joint dysfunction (TMJ);

- for or in connection with infertility treatment of any kind, regardless of the recipient's sex, including but not limited to in vitro fertilization, artificial insemination or similar procedures; infertility drugs; gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), artificial insemination (AI) and variations of these procedures; any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees); infertility services when the infertility is caused by or related to voluntary sterilization; cryopreservation of donor sperm and eggs; and any Experimental/Investigational infertility procedures or therapies;

- for or in connection with procedures to reverse sterilization or reversal of voluntary sterilization;

- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction;

- for medical and surgical services intended primarily for the treatment or control of obesity. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass;

- unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or Hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations;

- for therapy to improve general physical condition if not Medically Necessary, including (but not limited to) routine, long-term Chiropractic Care and rehabilitative services

which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected;

- for any services or supplies provided for the following treatment modalities: acupuncture, video fluoroscopy, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as isostation, digital myograph, and dynatron;

- consumable medical supplies, including but not limited to: Bandages and other disposable medical supplies, skin preparations and test strips, except as provided under "Covered Expenses;"

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics (except in the treatment of diabetes), elastic stockings, garter belts, corsets, hearing aids, dentures and wigs;

- for hygienic or self-help items or equipment;

- for items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;

- for environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;

- for institutional equipment, such as air fluidized beds and diathermy machines;

- for equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;

- for items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;

- for items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars;

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;

- 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 Sickness or Injury;

- for or in connection with Custodial Services, education or training;

- for Charges made for any non-Prescription Drugs prescribed or recommended for a person;

- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicare or Medicaid;

- to the extent of the exclusions imposed by the Certification Requirements shown in the Schedule of Benefits;

- for Charges made by a Physician for or in connection with surgery which exceed the following maximum when 2 or more surgical procedures are performed at one time: The maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures; for multiple surgeries with Charges above the Allowable Amount for the single procedure with the highest Allowable Amount plus one-half of the Allowable Amount for each of the other covered procedures performed;

- for Charges for or in connection with a pre-planned home delivery of a child;

- for Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;

- for Charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including but not limited to, the removal of calluses and corns or the trimming of nails unless Medically Necessary;

- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered Custodial Care or educational; or (c) is intended to maintain speech communication;

- Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Medical Plan Option for:

    - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claims Administrator, or

    - Benefits for Treatment of Diabetes;

- for Charges made by any covered provider who is a member of your family or your Dependent's family;

- for Experimental/Investigational services, which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices determined by the Claims Administrator to be:

    - not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The

United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal, or

- the subject of review or approval by an Institutional Review Board for the proposed use, or

- the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight, or

- not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed;

- for or in connection with an Injury or Sickness which is due to war, declared or undeclared; or, while on active or reserve duty in the armed forces of any country or international authority;

- for Expenses Incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the Charges are incurred while traveling on business or for pleasure;

- for non-medical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation;

- for medical treatment when payment is denied by the Medicare plan because treatment was received from a Non-Participating Provider;

- for medical treatment when payment is denied by a Primary Plan because treatment was received from a Non-Participating Provider;

- for travel, whether or not recommended by a Physician or other provider, except for local ground ambulance service or air ambulance service otherwise covered under the Medical Plan Option;

- for Charges which a Participant is not legally obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under a Medical Plan Option;

- for Charges resulting from the failure to keep a scheduled visit with a provider, or for completion of any insurance forms, or for acquisition of medical records;

- for Room and Board Charges incurred during a Hospital Admission for Diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting your physical condition or the quality of medical care provided;

- for any services or supplies provided before you are covered as a Participant or any services or supplies provided after the termination of your coverage;

- for any benefits in excess of any specified maximums;

- No payment will be made for Expenses Incurred by you or any one of your Dependents:

    - to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

        - a "no-fault" insurance law, or

        - an uninsured motorist insurance law;

- The Claims Administrator will take into account any adjustment option chosen under such part by you or any one of your Dependents;

- for or in connection with an elective abortion unless:

    - the Physician certifies in writing that the pregnancy would endanger the life of the mother, or

    - the expenses are incurred to treat medical complications due to the abortion.

- Chantix Prescription Drugs and any other Prescription Drugs that may be excluded by the Company's regulators (e.g. DOT, FMCSA, etc.). For a complete list of Prescription Drugs (including specific J Codes) that are excluded under the Medical Plan Options but remain covered under the Prescription Drug portion of the Medical Plan Options, administered by Express Scripts, please call Express Scripts at 1-855-315-6433.

- Marijuana of any kind including medicinal or recreational marijuana in any form including edible and smokeable forms.

See additional items specific to "Mental Health and Substance Abuse Services" listed in Subsection 4.3.21.6, "Exclusions" for additional excluded services.

7. TERMINATION OF COVERAGE

7.1 Termination of Coverage - Teammates

Your coverage will cease on the earliest date below:

- the last day of the pay period you cease to be in a Class of eligible Teammates or otherwise cease to qualify for the coverage;
- the last day of the pay period for which you have made all required contributions for the coverage;
- the last day of the pay period after your Active Service ends, except as described under "Leave of Absence;" or
- the date the Medical Plan Option that you participate in under the Plan is canceled or terminated.

7.2 Termination of Coverage – Dependents

Coverage for all of your Dependents will cease on the earliest date below:

- the last day of the pay period for which your coverage ceases;
- the last day of the month in which a Dependent Child attains age 26 unless your Child is permanently and totally disabled (See Section 2.9);
- the last day of the pay period for which all required contributions for the coverage have been made; or
- the last day of the pay period for which Dependent Coverage is canceled.

Unless otherwise specified above, the coverage for any one of your Dependents will cease on the last day of the pay period in which that Dependent no longer qualifies as a Dependent if you pay your portion for the coverage.

7.3 Leave of Absence

If you intend to take a leave of absence from work, please refer to the Company's policies for leaves of absences including leaves under the Family and Medical Leave Act of 1993 or contact the Company for additional information about your rights to continued health coverage.

Any provisions of the Medical Plan Options that provide for: (a) continuation of coverage during a leave of absence; and (b) reinstatement of coverage following a return to Active Service, are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable.

7.3.1 Continuation of Health Coverage During Leave

Medical coverage may be maintained during the first six months of approved leave. Payments are required according to the Company's Leave of Absence Policies.

If you fail to timely make required premium payments by the date communicated to you by the Plan Administrator for health coverage while out on any unpaid leave of absence, including but not limited to, a FMLA leave, your coverage may be cancelled and, if cancelled, cannot be reinstated if you do not return to work. In addition, in this case you may **lose** your right to continue your health coverage pursuant to COBRA.

If you do not continue health coverage or your health coverage is otherwise lost due to your failure to make required premiums as provided above, but you do return to work from your unpaid leave:

- In leaves other than FMLA leaves (or if you come back to work after your FMLA leave has expired), you will be required to wait until the next Open Enrollment Period to reinstate your health coverage; and

- If you timely return to work on or before the date your available FMLA leave expires, you:

    - Have a right to reinstate your health coverage prospectively by resuming premium payments, and

    - May retroactively reactivate health benefits for the period that you were out on an unpaid FMLA leave, as long as you timely pay all outstanding health premiums for the FMLA leave in the form and manner communicated to you by the Plan Administrator.

7.3.2 Reinstatement of Canceled Coverage Following Leave

If you return to Active Service from an approved FMLA leave and you had a lapse in medical coverage during your leave due to non-payment of medical premiums, you may be reinstated in the applicable Medical Plan Option if requested within 31 days of your return. Any canceled coverage will be reinstated as of the date of your return, but subject to any changes in benefit levels that may have occurred during the leave that affected the entire work force.

You will not be required to satisfy any eligibility Waiting Period to the extent that you had satisfied the Waiting Period prior to the start of such FMLA leave.

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

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to

military leaves of absence. Coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of six months or more, you may continue coverage for yourself and your Dependent as follows:

> If the Company is subject to federal continuation requirements called COBRA, you may continue benefits according to the federal continuation benefits shown in your SPD. You and your Dependents will be charged up to 102% of the total cost.
>
> The maximum period of Medical Plan Option coverage available to a Teammate and his Dependents will not exceed the lesser of (1) 24 months or (2) the period ending on the day after the date upon which you fail to apply for a return to a position of employment under section 4312(a) of USERRA. The period of this coverage shall begin on the date on which your qualifying absence begins.

If your coverage ends during the leave because you do not elect COBRA or an available conversion plan at the expiration of COBRA and you are reemployed by the Company, coverage for you and your Dependents may be reinstated if: (a) you gave the Company advance written or verbal notice of your military service leave; and (b) the duration of all military leaves while you are employed with the Company does not exceed 5 years.

You and your Dependents will be subject only to the balance of a Waiting Period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Medical Plan Option limitations will apply.

7.5 Continuation Required by Federal Law (COBRA) for You and Your Dependents

This communication is provided as part of a legal requirement to advise you of your COBRA Coverage rights, in the event you or your covered Dependents should have the need for COBRA coverage in the future. No action is required at this time. However, you are responsible for keeping the Company aware of changes that occur such as addresses (for both you and your Dependents), divorce, your Spouse's eligibility for Medicare, etc.

In accordance with a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), the Medical Plan Options under this Plan offer you and your covered family members the opportunity to extend existing health coverage (COBRA) when your current Employer provided coverage ends due to a Qualifying Event. Read this notice carefully as you and your covered Dependents each have an independent right to elect or reject COBRA. For example, if you reject COBRA coverage, your Spouse and/or Dependents may still elect COBRA for themselves. If your Dependents are minor children, either you or your Spouse may elect or reject COBRA on their behalf.

Retain this notice in your permanent records. It is your responsibility to keep the Company informed of any address change in a timely manner in order to receive all information about COBRA prior to or after a COBRA election.

7.5.1 What Qualifying Events Entitle me to Elect COBRA Coverage?

If you are a Teammate, you have a right to elect COBRA Coverage beginning from the date coverage is lost due to:

- A reduction in hours; or
- Termination of employment.

Your Spouse has the right to elect COBRA beginning from the date coverage is lost due to:

- Your death ;
- Your termination of employment;
- Your reduction in hours;
- Divorce or legal separation; or
- You become entitled to Medicare.

Your Dependent Child has the right to elect COBRA beginning from the date coverage is lost due to:

- Your death;
- Your Termination of employment;
- Your reduction in hours;
- Divorce or legal separation of Teammate;
- You become entitled to Medicare; or
- Dependent Child no longer qualifies as a Dependent.

7.5.2 What is COBRA Coverage?

COBRA coverage is coverage identical to coverage provided by the Company for similar Teammates or family members. In most cases, you will have the same coverage under COBRA as you did before a Qualifying Event occurred. **You may continue any medical coverage under the Medical Plan Options.** COBRA is subject to eligibility and the

Administrator reserves the right to terminate COBRA coverage retroactively if you are found ineligible. This applies even if a COBRA payment has been accepted.

7.5.3 Can I Add a Newborn, Newly Adopted Child, Child Who has Been Placed for Adoption to my COBRA Coverage?

You may add a newborn, newly adopted child, or a child Placed for Adoption with you to your COBRA Coverage within 60 days of the occurrence. If you enroll a newborn, adopted child, or child Placed for Adoption who later loses coverage as a result of a Qualifying Event, they are considered a Qualified Beneficiary with independent COBRA election rights.

7.5.4 How should I Obtain COBRA Coverage?

To obtain COBRA, you, your family members and the Company or the Plan Administrator must satisfy certain notification requirements. This means that you or your family members must notify the Company or the Plan Administrator at the address set forth below in Section 7.5.12 of certain Qualified Events described in this Section. Notice must be given within 60 days of the later of the Qualifying Event or the date coverage ends. ***If you fail to timely and properly provide this notice, you will lose the right to elect COBRA Coverage and your right to continue medical coverage will end.*** **You must provide notice to the Company or the Plan Administrator of these Qualifying Events:**

- Your divorce or legal separation; or
- Your Dependent loses Dependent status.

The Company or the Plan Administrator will notify you and your covered qualified beneficiaries, as appropriate, of the right to continue coverage under COBRA within 44 days after the date coverage ends due to one of the Qualifying Events:

- Your death;
- Your termination of employment;
- Your reduction in hours;
- Your becoming entitled to Medicare; or
- Company's bankruptcy.

You have 60 days from the later of the date you lose coverage due to a Qualifying Event or the date the Company or the Plan Administrator informs you of your right to elect COBRA Coverage. ***If you do not elect COBRA Coverage within this 60-day period, your option to elect coverage under a Medical Plan Option ends***.

The duration of COBRA Coverage depends on the reason coverage was lost. Once you elect COBRA, it is imperative that you make timely payments and comply with any other requirements set forth by the COBRA laws:

Qualifying Event	**Possible COBRA Period (Months)**
Termination of Employment	UP TO 18 months
Reduction in Hours	UP TO 18 months
Disability	UP TO 29 months
Divorce or Legal Separation	UP TO 36 months
Death	UP TO 36 months
Loss of Dependent Child Status	UP TO 36 months
Medicare Entitlement	UP TO 36 months

Special rules apply to extend COBRA Coverage based on successive Qualifying Events as well as Social Security disability. If you are a Spouse or Dependent of a Teammate, COBRA may be extended for up to a total of 36 months from the loss of coverage following the original date of the Teammate's termination or reduction in hours, if successive Qualifying Events occur. COBRA will not last beyond 36 months from the loss of coverage following the date of the original Qualifying Event that made the individual eligible for COBRA. A successive qualifying event is:

- Death of Teammate;
- Divorce or legal separation;
- Medicare entitlement; or
- Loss of Dependent status.

Successive Qualifying Events must occur within the original 18 month COBRA period and you must notify the Company or the Plan Administrator in writing within 60 days of a successive qualifying event. ***If you do not provide this notice timely, the right to extend coverage is lost.***

COBRA may be extended for up to a total of 29 months if you, your Spouse or your Dependent child is disabled as determined by the Social Security Administration on one of the following:

- Your date of termination or reduction in hours
- Within the first 60 days of the 18-month COBRA period

You must notify the Company or the Plan Administrator of the Social Security Administration's determination within 60 days of receiving such determination and before the end of the original 18-month maximum COBRA period that applies to the Qualifying Event. You must also provide the Company or the Plan Administrator with a copy of the Notice of Award letter from the Social Security Administration. ***If this notice is not provided timely, the right to extend coverage for up to 29 months is lost.***

Note: You or your family member must notify the Company or the Plan Administrator within 31 days of any final determination by the Social Security Administration indicating the individual is no longer disabled. If the individual is no longer disabled, COBRA ends at the end of the original 18-month period or the end of the current month, if the current month is after the original 18-month period.

7.5.5 What Happens if I become Entitled to Medicare?

If you become entitled to Medicare during the 18-month period prior to a termination of employment or reduction in hours, COBRA may be extended for your covered Spouse and Dependents up to 36 months from the date of Medicare entitlement. *For example, if you become entitled to Medicare and terminate employment 6 months later, your Qualified Beneficiaries are entitled to elect COBRA for up to 30 months from the date of termination.*

7.5.6 What Happens if I become Entitled to Trade Assistance

If you terminate employment from the Company and you fail to elect continuation benefits, and you later become eligible for trade assistance (as that term is defined in the Trade Act of 2002), you may be eligible to re-elect continuation benefits. Please see the Company for more details if you think you may be affected.

7.5.7 Who Pays for Coverage?

You pay 100% of the monthly premium for COBRA Coverage and the Company may charge a 2% administration fee unless you are eligible for the trade assistance subsidy explained in the Section above. If you or your family members are entitled to a continuation based on disability, the Company may charge you 150% of the monthly premium during the additional up-to-11-month coverage period.

7.5.7.1 How Does COBRA Help with Special Enrollment Periods

COBRA <u>may</u> allow you to take advantage of "Special Enrollment Periods" in your new employer's plan. Employer plans are required to have special enrollment periods for individuals who did not elect coverage when first eligible because they had COBRA Coverage. Specifically, an employer's Plan must allow such individuals to enroll in the plan within 30 days after exhausting COBRA Coverage.

7.5.8 Election and Payment Deadlines

You have 60 days to elect COBRA Coverage from the later of the date you lose coverage due to a Qualifying Event or the date the Company or the Plan Administrator informs you of your right to elect COBRA Coverage. If you do not elect COBRA Coverage within this 60-day period, your option to elect coverage under a Medical Plan Option ends.

All retroactive payments are due within 45 days after your COBRA election is received and processed. COBRA Coverage cannot be verified until the election form and the retroactive payment are received. Your initial payment must cover the entire period from the date of the Qualifying Event to the current date. *For example, if you elect COBRA on the last day of the 60-day election period, your initial payment is for the first 2 months of COBRA Coverage.*

Generally, premiums are due on the 1st of the month and must be paid by personal or certified check. However, there is a 30-day grace period for payment. To qualify for the grace period, your payment must be postmarked or received by the Company or the Plan Administrator no later than 30 days after the due date.

7.5.9 COBRA Coverage can Terminate Early

If you are a Teammate or Spouse or Dependent of a Teammate, COBRA may end early for *any* of the following reasons:

- Employer no longer provides group health coverage;
- Premium is not paid on time;
- You become covered under another plan;
- You become entitled to Medicare; or
- Coverage was extended due to disability and there is a final determination by the Social Security Administration that you are no longer disabled.

7.5.10 May I convert COBRA to an Individual Policy?

There is no conversion option for the Medical Plan Options offered under the Plan.

7.5.11 Do I have any other Continuation of Coverage Options?

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. Please note that certain Excepted Benefits such as health flexible spending accounts, integrated health reimbursement arrangements, or standalone vision or dental plans will not be offered under the Marketplace or included as a special enrollment right. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your

monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. 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. When weighing your coverage options, you should consider premium costs, whether a change in coverage will affect your access to certain providers, service areas or drug formularies and whether the coverage change will affect your cost sharing (for example, new deductibles, higher copays etc.). For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assistor in your area who you can talk to about the different options, visit www.HealthCare.gov.

7.5.12 Questions and Contact Information

You should provide written notice to the Company or the Plan Administrator of certain Qualifying Events as described in Section 7.5.4 above at the following address:

McLane Company
4747 McLane Parkway
P.O. Box 6115
Temple, TX 76503-6115

You may also contact the Plan Administrator at 1-254-771-7500 or 1-888-463-6089 if you have any questions concerning COBRA coverage. In addition, it is your responsibility to keep the **Plan Administrator informed of any change of address for you or any of your covered Dependents since information concerning your COBRA rights will be sent to your last known address.**

8. IMPORTANT NOTICES

8.1 Coverage for Reconstructive Surgery Following Mastectomy / 1998 Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Medical Plan Options cover mastectomies and comply with this law.

If you receive coverage for a mastectomy, the law requires the Plan to provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis;
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage is provided in consultation with the attending Physician and patient, and is subject to the same annual Deductibles and Coinsurance provisions that apply for the mastectomy.

If you have any questions about coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your medical ID card.

8.2 Coverage For Maternity Hospital Stay

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, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable. Please review the Medical Plan Options of this Plan for further details on the specific coverage available to you and your Dependents.

8.3 Medicaid

The Medical Plan Options of the Plan will not take into account your eligibility or your Dependents' eligibility for health assistance or benefits payable under 42 U.S.C. § 1396 et seq., except as necessary to comply with the special enrollment rights under Medicaid and CHIP.

8.4 Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008.

The Medical Plan Options of the Plan will comply with the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008 with respect to mental health and substance use benefits.

8.5 Medicare

Unless you elect Medicare as your primary plan, the Medical Plan Options under this Plan will pay first for:

- You, if you are an active Teammate who is age 65 and over; or
- Your Dependent Spouse age 65 and over, if you are an active Teammate; or
- Your disabled Dependent under age 65, if you are an active Teammate; or
- the number of months as specified by regulation of the Centers for Medicare and Medicaid Services for treatment of end stage renal disease received by any Participant;

unless the Participant rejects, in writing, coverage under the Medical Plan Options of this Plan..

Special rules apply when you are covered by the Medical Plan Options of this Plan and by Medicare. Generally, the Medical Plan Options under the Plan is a primary plan if you are an active Teammate, and Medicare is a primary plan if you are a retired Teammate.

8.6 Notice Regarding Provider Directories and Provider Networks

You will find the most current listing of Participating Providers online. Go to: https://www.bcbstx.com/mclane or contact customer service at 1-866-363-7936, and for the pharmacy network go to http://www.expresss-scripts.com or call 1-855-315-6433. The website administrators have made reasonable efforts to validate that the list of providers displayed is up to date and accurate. It is your responsibility to call the provider prior to scheduling an appointment to verify that the provider continues to be part of the network.

Your Participating Provider network consists of retail pharmacies, a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by, or contracted with, the Claims Administrators, Blue Cross and Blue Shield or Express Scripts.

8.7 Notification of Self-Insurance

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS SPD OR ANY ATTACHMENTS HERETO ARE SELF-INSURED BY THE COMPANY, WHICH IS RESPONSIBLE FOR PAYING THE BENEFITS. BLUE CROSS AND BLUE SHIELD OF TEXAS (BCBSTX) AND EXPRESS SCRIPTS PROVIDE CLAIM ADMINISTRATION SERVICES, BUT THEY DO NOT INSURE ANY BENEFITS UNDER THE MEDICAL PLAN OPTIONS.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE BLUE CROSS AND BLUE SHIELD OF TEXAS AND/OR EXPRESS SCRIPTS AS THE CLAIMS ADMINISTRATOR.

8.8 Arbitration

To the extent permitted by law, any controversy between the applicable Claims Administrator and the Medical Plan Option, or a Participant (including any legal representative acting on behalf of a Participant), arising out of or in connection with this SPD may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall

choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrators shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question and enforceable in any court of competent jurisdiction.

No party to this SPD shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this SPD pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this SPD.

8.9 Amendment and Termination of the Medical Plan Options

The Plan Sponsor may amend or terminate all or any part of the Medical Plan Options offered under the Plan at any time. The Plan Sponsor has delegated authority to the Director of Benefits, or any successor to this position, to make amendments to the Medical Plan Options under the Plan that (1) do not significantly increase the costs of the Medical Plan Option, or (2) are required to be made by law. The Medical Plan Options may be amended or changed at any time by the Company with written notice to the Claims Administrator. No consent or advance notice to any Participant is necessary to amend or change the Medical Plan Options under the Plan.

8.10 Administration of the Medical Plan Options

The primary responsibility for the general administration of the Medical Plan Options is placed with the Plan Administrator. However, the applicable Claims Administrator is responsible for processing and deciding all claims. The applicable Claims Administrator has the exclusive right to make all determinations concerning eligibility for coverage and benefits under the Medical Plan Options. The Plan Administrator or the Claims Administrator, as appropriate, in its sole discretion, shall have the power to make reasonable rules and regulations, to make all determinations necessary for the administration of the Medical Plan Options under the Plan and to interpret the terms of the Medical Plan Options under the Plan. Their determinations and interpretations shall be binding and conclusive on all persons.

8.11 Important Information

The name of the Plan is McLane Company, Inc. Welfare Plan. This SPD describes only the Medical Plan Options offered under the Plan.

The Plan Sponsor's name, address and telephone number is:

McLane Company, Inc.
4747 McLane Parkway
P.O. Box 6115
Temple, TX 76503-6115
Tel: 1-254-771-7500

No oral interpretations can change the Medical Plan Options offered under this Plan. The Medical Plan Options described are designed to provide Plan Participants with certain health expenses.

Your coverage and your Dependent's coverage under the Medical Plan Options will take effect when you have satisfied the eligibility requirements, including any applicable Waiting Period, and you enroll yourself and your Dependents in the coverage.

The Company intends to maintain the Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Medical Plan Options offered under the Plan at any time and for any reason. Changes in the Medical Plan Options may occur in any or all parts of the Medical Plan Options including benefit coverage, Deductibles, maximums, Copays, Coinsurance, exclusions, limitations, definitions, eligibility and the like. If the Medical Plan Options under the Plan are terminated, amended, or benefits are eliminated, the rights of Participants are limited to Covered Expenses incurred before termination, amendment or elimination.

Failure to follow the eligibility or enrollment requirements of the Medical Plan Options under the Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the applicable Medical Plan Options, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of pre-certification, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this SPD.

The Medical Plan Options will pay benefits only for the Expenses Incurred while coverage under a Medical Plan Option is in force. No benefits are payable for Expenses Incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, Injury or Sickness that occurred, began or existed while coverage was in force. An Expense Incurred for a service or supply is incurred on the date the service or supply is furnished.

8.12 Other Employers Participating in the Plan

Although the Plan Sponsor or Company is the most significant Employer maintaining the Medical Plan Options under the Plan, the Medical Plan Options under the Plan provide for the possibility of adoption by affiliated companies. You and your covered Dependents may, upon written request to the Plan Administrator, receive information as to whether a particular Employer is a sponsor and, if so, the address of that Employer.

Plan Sponsor's Identification Number:

74-1478631

Plan Number:

502

Plan Type:

The Plan is a welfare plan providing a variety of welfare benefits. Only the Medical Plan Options which provide health benefits under the Plan are described in this SPD.

Type of Administration:

The Medical Plan Options of the Plan are self-funded by the Company, who is also the Plan Administrator. The Plan Administrator for the Medical Plan Options has the full power to control and manage all aspects of the Medical Plan Options in accordance with its terms and all applicable laws. The Plan Administrator may allocate or delegate its responsibilities for the administration of the Medical Plan Options to others and employ others to carry out or give advice with respect to its responsibilities under the Medical Plan Options. Various aspects of the Medical Plan Options are administered by Blue Cross and Blue Shield of Texas or Express Scripts. BlueCross BlueShield of Texas serves as the medical Claims Administrator and Express Scripts serves as the pharmacy Claims Administrator.

BCBSTX provides administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

The name, address, ZIP code and business telephone number of the Plan Administrator is:

McLane Company
4747 McLane Parkway
P.O. Box 6115
Temple, TX 76503-6115
Tel: 1-254-771-7500

The name, address, ZIP code and business telephone number of the Claims Administrator are:

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, Texas 75266-0044
Tel: 1-866-363-7936

Express Scripts
One Express Way
St. Louis, MO 63121
Tel: 1-855-315-6433
Express-scripts.com

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Same as Plan Administrator named above.

Service of legal process may also be made upon the Plan Administrator and a trustee (if any).

8.12.1 Plan Year

The fiscal records of the Plan are maintained on the basis of the Plan Year, which is each 12-month period beginning January 1st and ending December 31st.

8.12.2 Summary of Benefits

The benefits available, as well as the procedures for presenting claims for benefits and for the redress of claims denied under the Medical Plan Options, are summarized in the SPD. Copies of this SPD are available upon request without cost to you and your covered Dependents.

8.12.3 Funding

The Medical Plan Options under the Plan are self-funded by your contributions and contributions by the Company. You make your contributions on a pre-tax basis under the Flexible Benefits Plan.

8.13 ERISA Rights Statement

As a Participant in a Medical Plan Option under the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Plan Participants shall be entitled to:

8.13.1 Receive Information About Your Medical Plan Option and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Medical Plan Options of 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 Medical Plan Options under the Plan, including insurance contracts and collective-bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

- Receive a summary of the annual financial report of the Medical Plan Options offered under the Plan. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

8.13.2 Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under a Medical Plan Option of 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 federal continuation coverage rights.

8.13.3 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

8.13.4 Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons

beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

8.13.5 Assistance with Your Questions

If you have any questions about your 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 in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

8.14 Disclosure Authorization

A physical examination will not be required in connection with your application for coverage under the Plan. It will be necessary, if you file a claim for benefits, that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claims Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your covered Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

9. DEFINITIONS

Active Service - You will be considered in Active Service:

- on any of the Company's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at the Company's place of business or at some location to which you are required to travel for the Company's business.

- on a day which is not one of the Company's scheduled work days if you were in Active Service on the preceding scheduled work day, or

- if your employment status in not "terminated."

Adverse Benefit Determination means any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of your or your beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes a retroactive cancellation or discontinuance of coverage under the Plan.

Allowable Amount means the maximum amount determined by the Claims Administrator to be eligible for consideration of payment for a particular service, supply, or procedure.

1. For Hospitals and Facility Other Providers, Physicians and Professional Other Providers Contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield plan - The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedules, package pricing, global pricing, per diems, case-rates, discounts or other payment methodologies.

2. For Hospitals, Other Health Care Facilities, Physicians and Other Health Care Professionals who are Non-Participating Providers, the "Allowable Amount" equals the lesser of:

   (a) The Non-Network Provider's billed charge; or

   (b) The Claims Administrator's non-contracting allowable amount ("Non-Contract Allowance").

   The Non-Contract Allowance equals an amount determined and developed solely by the Claims Administrator, using:

   (i) Base Medicare reimbursement rates, as adjusted by a predetermined factor ("Factor"), with new rates to be effective within 90 days after a change is implemented by the Centers for Medicaid and Medicare Services, or its successor, and

   (ii) The same claim processing rules and/or edits as used for Participating Providers which may also alter the Non-Contract Allowance for such Non-Network Provider claim; but if the Claims Administrator has no edits or rules for such claim, then the Claims Administrator may use Medicare rules or edits for such claim; and

(iii) Notwithstanding the above, for Home Health Care Services only, the base Medicare national per visit amounts for low utilization payment adjust ("LUPA") episodes by Home Health Care Services discipline type, adjusted for duration and by the Factor; and

In all instances, the Non-Contact Allowance excludes any additional payments that may be permitted by Medicare which are not directly attributable to a specific claim, such as (among others) disproportionate share and graduate medical education payments.

The Factor in determining the Non-Contract Allowance equals a factor established by the Claims Administrator, updated periodically, at a percentage not less than 75% (excluding any Medicare adjustments) and based upon information on a submitted claim.

Notwithstanding the above, when Medicare reimbursement rates are not available or cannot be determined by the Claims Administrator, the Non-Contract Allowance is the average aggregate contract rate for Participating Providers, adjusted by the Factor, which will be updated by the Claims Administrator at least every two years.

Notwithstanding the above, for procedures, services, or supplies performed outside of Texas by Physicians, Professional Other Providers, Hospitals and Facilities not contracting with BCBSTX or any other Blue Cross and Blue Shield plan, the Non-Contract Allowance, outside of Texas, will never exceed two (2) multiplied by the Medicare reimbursement rate.

For example, the Claims Administrator can limit benefits for out-of-network claims outside of Texas and the "Allowable Amount" to 200% of the Medicare reimbursement rate for any particular procedure, service or supply if the billed charge is greater.

Participants are responsible for any difference between:

(i) The Non-Network Allowance payable to the Non-Network Provider (this may be considerable), and

(ii) The Non-Network Provider's billed charge.

You may contact the Claims Administrator if you want to know the Non-Network Allowance payable to a Non-Network Provider for a particular procedure, service or supply.

3. For multiple surgeries: The Allowable Amount for all surgical procedures performed on the patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus 1-half of the Allowable Amount for each of the other covered procedures performed.

4. For drugs administered by a Home Infusion Therapy Provider - The Allowable Amount will be the lesser of: (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark-down from the AWP established by the Claims Administrator and updated on a periodic basis.

5. For procedures, services or supplies provided to Medicare recipients: The Allowable Amount will not exceed Medicare's limiting charge.

CAT means Computerized Axial Tomography.

Charges means the actual billed Charges, except when the provider has contracted directly or indirectly with the Claims Administrator for a different amount.

CHIP means a state children's health insurance program under Title XXI of the Social Security Act.

Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion reduce pain and improve function.

Claims Administrator means Blue Cross and Blue Shield of Texas (BCBSTX) or Express Scripts. BCBSTX or Express Scripts, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities. Claims Administrator may also mean any successor named by the Plan Administrator.

Coinsurance means the percentage of Charges for Covered Expenses that a Participant is required to pay under the Medical Plan Option after any applicable Copays and Deductibles are satisfied.

Company means McLane Company, Inc., the Plan Sponsor self-insuring the benefits described in this SPD, on whose behalf Blue Cross and Blue Shield of Texas and Express Scripts are providing claim administration services. The Teammates of the Plan Sponsor and its eligible U.S. subsidiaries participate in this Plan.

Copays are dollar amount expenses to be paid by you or your Dependent to the provider for the services received. If the services provided by the Participating Provider require a return office visit, a new Copay amount will be required.

Cosmetic Surgery means a procedure performed primarily to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to a Sickness or Injury.

Covered Expenses means the Expenses Incurred by or on behalf of a Participant for Charges for eligible benefits under the Medical Plan Option, if they are incurred after he/she becomes covered for benefits. Expenses Incurred for such Charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary and are those Charges negotiated with or determined by the Claims Administrator to be the Allowable Amount. Any applicable Copays, Coinsurance, Deductibles or Maximums are shown in the Schedule of Benefits.

Custodial Care means care comprised of services and supplies, including Room and Board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of Sickness or Injury. Custodial Care is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

Custodial Service means any services which are not intended primarily to treat a specific Injury or Sickness (including Mental Health and Substance Abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;

- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and

- services not required to be performed by trained or skilled medical or paramedical personnel.

Deductibles are the amount of Covered Expenses (medical and/or pharmacy) to be paid by you or your Dependent to the provider before specific benefits under the Plan become payable by the Plan. Deductible amounts are separate from and are not reduced by Copays. Deductibles accumulate on a Plan Year basis.

Dependent(s) are your legal Spouse and your Children as defined in Section 2.9 of this SPD.

Diagnostic x-ray and laboratory (Laboratory and Radiology Services) includes bone scan, cardiac stress test, CT scan (with or without contrast), MRI (Magnetic Resonance Imaging), Myelogram, PET scan (Positron Emission Tomography), and Ultrasound. *This list is not inclusive and may be modified from time to time.*

Driver means a Teammate who is classified as a Driver by the Employer.

Durable Medical Equipment means equipment which:

- can withstand repeated use by more than one person;

- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury;
- is appropriate for use in the home; and
- is not disposable.

Elective Surgical Procedure means a surgical procedure which is not considered emergency in nature and which may be avoided or delayed without undue risk to the individual.

Emergency Services refers to medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

Excepted Benefits means the following benefits:

- coverage only for accident or disability income insurance or any combination thereof;
- coverage issued as a supplement to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance;
- coverage for on-site medical clinics; and
- other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- If not an integral part of a group health plan:

- limited scope dental or vision benefits;
- benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
- other similar limited benefits as specified in regulations.

- If offered as independent non-coordinated benefits (separate consent or policy, no Coordination of Benefits with any other plan sponsored by the Company):
  - coverage for a specified disease or illness;
  - hospital indemnity or other fixed indemnity insurance.
- If offered as separate insurance policy, Medicare supplemental health insurance and similar supplemental coverage.
- Benefits provided under a health flexible spending arrangement for individuals that meet the requirements under Treasury Regulations section 54.9831-1(a)(3)(v).

Expense Incurred means the date the service or supply is furnished.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical treatment of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

Extended Care Expense means charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice.

Flexible Benefit Plan means the McLane Company, Inc. Flexible Benefit Plan which allows pre-tax contributions.

Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least 2 operating rooms and 1 recovery room;
- it maintains Diagnostic laboratory and x-ray facilities; it has equipment for emergency care;
- it has a blood supply;

- it maintains medical records;

- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement / Admission on an inpatient basis; and

- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Health Status - Related Factor means the following factors:

- health status,

- medical condition (include both physical and mental illnesses),

- claims experience,

- receipt of health care,

- medical history,

- Genetic Information,

- evidence of insurability (including conditions arising out of acts of domestic violence), and

- disability.

Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Health Care Agency.

Home Health Care Agency means a Hospital or a profit or public Home Health Care Agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;

- is run according to rules established by a group of professional persons;

- maintains clinical records on all patients;

- does not primarily provide Custodial Services or Custodial Care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide Home Health Care Services.

Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement/admission in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the Medical Plan Option.

Home Health Care Services means those skilled health care services that can be provided during intermittent visits of 2 hours or less by Other Health Care Professionals. Home Health Care Services do not include services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

- Drugs and IV solutions;
- Pharmacy compounding and dispensing services;
- All equipment and ancillary supplies necessitated by the defined therapy;
- Delivery services;
- Patient and family education;
- Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;

- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally III patients;
- is accredited by the National Hospice Organization;
- meets standards established by the applicable Claims Administrator; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital means:

- an institution licensed as a Hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals;
- an institution which: (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency; or
- a Free-standing Surgical Facility.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement, Hospital Admission or Confined in a Hospital - A person will be considered Confined in a Hospital if he is:

- A registered bed patient in a Hospital upon the recommendation of a Physician. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Plan,
- Receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program,

- Receiving treatment for Substance Abuse in a Substance Abuse Intensive Therapy Program,

- Receiving treatment in a Mental Health Residential Treatment Center.

HSA means a Health Savings Account.

Hourly Teammate means a Teammate who is compensated on an hourly basis and who is classified as an hourly Teammate by the Company (not a Driver).

Injury means an accidental bodily injury.

Lifestyle Drug means a drug that is not Medically Necessary to sustain a healthy life. Lifestyle Drugs are designed to improve the quality of a healthy life.

Maintenance Treatment means treatment rendered to keep or maintain the patient's current status.

Marketplace means a competitive marketplace established under § 1311 of the Patient Protection and Affordable Care Act, commonly referred to as an Exchange or a Health Insurance Marketplace.

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity means those Services or Supplies covered under the Medical Plan Option which are determined by the Claims Administrator to be:

(a) no more than required to meet the basic health needs of the Participant;

(b) consistent with the diagnosis of the condition for which they are required;

(c) consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research;

(d) required for purposes other than the comfort and convenience of the patient or their Physician;

(e) rendered in the least intensive setting that is appropriate for the delivery of health care; and

(f) of demonstrated medical value.

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, Sickness or Mental Illness does not mean that it is a Medically Necessary Covered Expense. The definition of Medically Necessary relates only to coverage and differs from the way in which a Physician, engaged in the practice of medicine, may define Medically Necessary.

Medical Plan Option Service Area means the geographical area designated by the Claims Administrator which determines eligibility for In-Network and Out-of-Network benefits. To receive In-Network Benefits, as indicated on the applicable Schedule of Benefits, **you must** choose providers within the Network for all care **(other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and Other Health Care Facilities to serve Participants throughout the network plan service area. The pharmacy network has been established by Express Scripts and consists of retail pharmacies and Express Scripts' mail order pharmacy. Refer to your online Provider Directory or call customer service to make your selections.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system used, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;

2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:

a. Individual, group, family, or conjoint psychotherapy,

b. Counseling,

c. Psychoanalysis,

d. Psychological testing and assessment,

e. The administration or monitoring of psychotropic drugs, or

f. Hospital visits or consultations in a facility listed in subsection 5, below;

3. Electroconvulsive treatment;

4. Psychotropic drugs;

5. Any of the services listed in numbers 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

MRA means Magnetic Resonance Angiography

MRI means Magnetic Resonance Imaging

Necessary Services and Supplies includes:

- any Charges, except Charges for Room and Board, made by a Hospital or Hospice on its own behalf for medical Necessary Services and Supplies actually used during Confinement;

- any Charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and

- any Charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any Charges for special nursing fees, dental fees or medical fees.

Non-Participating Provider means any provider of medical services that does not have a written contract with the Claims Administrator to provide medical services to the Plan.

Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation R.N., L.P.N. or L.V.N.

Open Enrollment Period means the recurring time period each year usually held during the fall when Teammates can enroll in medical benefits for the Plan Year immediately following the recurring time period.

Other Health Care Facility means a facility other than a Hospital or a Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing Facilities, rehabilitation Hospitals and subacute facilities.

Other Health Care Professional means an individual, other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services. Other Health Care Professionals include, but are not limited to physical therapists, Home Health Aides and Nurses.

Out-of-Pocket Maximum is the maximum (expressed in dollars) during a Plan Year that a Plan Participant would pay in Coinsurance expenses for Covered Expenses incurred for Charges made by Participating (In-Network) and Non-Participating (Out-of-Network) Providers. Medical Deductibles, Copays, Coinsurance and any penalties paid (i.e. for not pre-authorizing a procedure) count toward the Medical Out-of-Pocket Maximum for the Core and Premium Medical Plan Options. Pharmacy Copays, Coinsurance and any amount paid for generic conversion count toward the Pharmacy Out-of-Pocket Maximum for Core and Premium Medical Plan Options. For generic conversion, if a member is prescribed a brand drug when script allows a generic substitution, or if a member chooses a brand, the difference in cost as well as the applicable brand Coinsurance will apply to the Out-of-Pocket Maximum. However, if your Physician requires a Prescription Drug to be Dispensed As Written (DAW), Pharmacy Copays, Coinsurance or any other amount paid

as a result of the DAW order will not be applied toward the Pharmacy Out-of-Pocket Maximum for the Core and Premium Medical Plan Options.

The Medical and Pharmacy Copays, Coinsurance and Deductibles accumulate to the Out-of-Pocket Maximum for the High Deductible Health Plan (see section "Out-of-Pocket Maximums" for more information). Out-of-Network Coinsurance for Covered Expenses also applies to the In-network Out-of-Pocket Maximum. Covered Expenses incurred during the Plan Year after the Out-of-Pocket Maximum has been met will be covered at 100%.

Participant means a Teammate or Dependent whose coverage has become effective under a Medical Plan Option under this Plan.

Participating Provider means:

- an institution, facility or agency which has entered into a contract with a Preferred Provider Organization (referred to as the PPO) to provide medical services at a predetermined cost in accordance with the agreement between the Claims Administrator and the PPO.

- a health care professional who has entered into a contract with a PPO to provide medical services at predetermined fees as negotiated by the Claims Administrator and that PPO.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers is available at https://www.bcbstx.com/mclane.

PET means Positron Emission Tomography

Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner if the practitioner is:

- operating within the scope of his license; and

- performing a service for which benefits are provided under a Medical Plan Option under this Plan when performed by a Physician.

Placed for Adoption or Placement for Adoption means the assumption and retention by the eligible Teammate of a legal obligation for total or partial support of a child in anticipation of adoption of such child prior to the date on which such individual attains age 18. The child's placement with such person terminates upon the termination of such legal obligation.

Plan Administrator means the named administrator of the Plan having fiduciary responsibility for its operation. Neither Express Scripts nor BCBSTX are the Plan Administrators. The Company is the Plan Administrator. (See "Important Information.")

Plan Year is on a calendar year beginning January 1st and ending December 31st.

PPACA means the Patient Protection and Affordable Care Act, commonly called Affordable Care Act (ACA), and is a United States federal statute signed into law by President Barack Obama on March 23, 2010.

Preauthorization establishes in advance the Medical Necessity of certain care and services covered under a Medical Plan Option of this Plan. It ensures that the preauthorized care and services will not be denied on the basis of Medical Necessity. However, Preauthorization does not guarantee payment of benefits. Coverage is always subject to other requirements of the Medical Plan Option, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided. (See "Certification Requirements" section for more information.)

Prescription Drug is any medication that requires a prescription from a Physician.

Preventive Care shall consist of (i) those items that are evidence based items or services rated A or B in the current recommendations of the United States Preventive Services Task Force ("USPSTF"), (ii) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, (iii) evidence-informed preventive care and screenings for infants, children, and adolescents, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), and (iv) additional preventive care and screenings for women as provided for in the comprehensive guidelines supported by the HRSA.

Primary Office Visit – Generally, an office visit to a General Practitioner, Family Practice, Pediatrician, Internal Medicine or Ob/Gyn Physician's office. Please note that there could be instances when a Primary Care Physician is contracted with the Claims Administrator as a Specialist. Please call the Claims Administrator to verify the Copay amount for the Physician you are planning to visit.

Psychologist means a person who is licensed or certified as a clinical Psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical Psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under a Medical Plan Option under this Plan when performed by a Psychologist.

Review Organization refers to an affiliate of the Claims Administrator or another entity to which the Claims Administrator has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Room and Board includes all Charges made by a Hospital or Hospice Facility on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Salaried Teammate means a Teammate who is paid compensation on a salaried basis and who is classified as a salaried Teammate by the Company. Drivers are not Salaried Teammates.

Serious Mental Illness means the following psychiatric illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);

2. Depression in childhood and adolescence;

3. Major depressive disorders (single episode or recurrent);

4. Obsessive-compulsive disorders;

5. Paranoid and other psychotic disorders;

6. Schizo-affective disorders (bipolar or depressive); and

7. Schizophrenia.

Sickness means a physical or mental illness. It also includes pregnancy. Expenses Incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital Nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility means a licensed institution (other than a Hospital) which specializes in:

- physical rehabilitation on an inpatient basis; or

- skilled nursing and medical care on an inpatient basis;

- but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Specialist Office Visit – An office visit with a practitioner who is not considered a Primary Care Physician (for example, a gastroenterologist or a neurologist).

Spouse means your legal Spouse, whether same-sex or opposite-sex, in a marriage validly entered into under the laws of a state of the United States or foreign jurisdiction having authority to sanction marriages. If you cover your Spouse, you may be asked to provide evidence of marriage, which may include a marriage certificate or other documentation satisfactory to the Pan Administrator. The Plan Administrator has the sole and absolute

authority to determine an individual's status as your Spouse and any such determination is final, binding and conclusive on all parties covered under the Plan.

Substance Use Disorder mean the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Teammate means a person who works for the Company and who is currently in Active Service.

Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of 6 months or less to live, as diagnosed by a Physician.

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by the Claims Administrator, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the covered Participant should not travel due to any medical condition.

Virtual Visit means an office visit that you have with a Participating Provider virtually (rather than in-person) through technology including computer internet communication or phone-video systems to diagnosis and treat non-emergency medical conditions.

Waiting Period means the period that must pass before you are eligible to be covered for benefits under the terms of the Medical Plan Options. Any period of time before a late enrollee enrolls under a Special Enrollment Period is not a Waiting Period.