GROUP HEALTH PLAN

PPO

Effective 01/01/2018

This booklet contains a summary in English of your Plan rights and benefits under the Tyson Group Health Plan. If you have difficulty understanding any part of this booklet, contact the Corporate Benefits Office at 2200 West Don Tyson Parkway, Springdale, AR 72762, (855) 328-5291, 8:00 a.m. to 5:00 p.m. CT.

Este folleto contiene un resumen en Inglés de sus derechos y beneficios bajo el Plan de Salud Grupal de Tyson. Si usted tiene dificultad en entender cualquier parte de este folleto, contacte a Corporate Benefits Office en 2200 West Don Tyson Parkway, Springdale, AR 72762, ó llame al (855) 328-5291 de 8:00 AM a 5:00 PM Hora del Centro.

Cuốn sổ nhỏ này chứa nội dung lợi ích và quyền của bạn theo Chương trình Sức khỏe Nhóm Tyson. Nếu bạn gặp khó khăn để hiểu rỏ bất kỳ phần nào trong cuốn sổ này, xin liên hệ với Phòng Lợi ích Công ty tại 2200 West Don Tyson Parkway, Springdale, AR 72762, (855) 328-5291, từ 8:00 sáng đến 5:00 giờ chiều, theo giờ Trung tâm.

يحتوي هذا الكتيب على موجز باللغة الإنجليزية بشأن الحقوق والفوائد الخاصة بك والتي تكتسبها من الخطة الصحية لمجموعة تايسون. إذا ما واجهت صعوبة في فهم أي جزء من هذا الكتيب، عليك بالاتصال بمكتب فوائد الشركة على العنوان التالي: 2200 West Don Tyson Parkway, Springdale, AR 72762، هاتف رقم 328-5291 (855)، من الساعة 8:00 صباحاً حتى الساعة 5:00 مساءً بالتوقيت المركزي.

Ova brošura sadržava na engleskom sažetak Vaših Plan prava i povlastica pod Tyson Group Health Planom. Ako imate poteškoće u razumijevanju bilo kog djela ove brošure, kontaktirajte Corporate Benefits Office (Ured za korporacijske povlastice) na 2200 West Don Tyson Parkway, Springdale, AR 72762, (855) 328-5291, 8:00 do 17:00 CT.

ປຶ້ມນ້ອຍຫ໊ອນີ້ປະກອບມີໃບສັງລວມສິດ
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ແມ່ນໃຫ້ຕິດຕໍ່ກັບຫ້ອງການສິດຜົນປະໂຫຍດຂອງບໍລິສັດໄດ້ທີ່ 2200 West Don Tyson Parkway, Springdale, AR 72762, (855) 328-5291, ເວລາແຕ່ 8:00 ໂມງເຊົ້າຫາ 5:00 ໂມງແລງຕາມເວລາ CT.

Buuggani waxaa si kooban ugu qoran xuquuqdaaada iyo daryeelkaaga qorshaha ee Qorshaha Caafimaadka Kooxda Tyson (Tyson Group Health Plan). Haddii dhib aad fahmi waydo qayb ka mid ah buugan, la xidhiidh Xafiiska Daryeelka Shirkadda (Corporate Benefits Office) oo ku yaal 2200 West Don Tyson Parkway, Springdale, AR 72762, (855) 328-5291, 8:00 a.m. ilaa 5:00 p.m. CT.

INTRODUCTION

Tyson Foods, Inc. maintains the Group Health Plan (the "Plan") for the benefit of eligible Employees and their eligible Dependents. The Plan provides medical, prescription drug, wellness, dental, and vision benefits, as described in this document. The benefits are "self-funded" directly by Tyson Foods as the "Plan Sponsor", although Tyson Foods generally collects contributions toward the cost of benefits from employees and other covered persons.

While the Plan is responsible for paying claims, Tyson Foods has contracted with various third party administrators for access to financial arrangements with providers through provider network agreements and for purposes of claims processing and determinations. Unless specifically named, each third party administrator is referred to in this document as the "Claims Administrator" with regard to the administrator's respective service area.

The following table lists the third parties along with the respective service area and contact information.

Name	Service Area	Contact Information
Enrollment Center (Aon)	New hire enrollment	www.benefitsquest.com/tyson 877-561-0240
BlueAdvantage Administrators of Arkansas (a division of Arkansas BlueCross BlueShield)	Medical claim status, access medical claims history, Healthy Tots®	www.tyson.blueadvantagearkansas.com 800-452-6199
Blue Cross & Blue Shield Network Medical Providers	Find in-network medical providers	www.ppo.tyson.com 800-810-2583
Progyny	Confirm eligibility and utilize a Progyny network provider to access fertility benefits	1-888-843-8912
CVS Caremark	Prescription drug inquiries, order and refill prescriptions, find a network pharmacy	www.caremark.com 800-390-2319
Delta Dental of Arkansas	Dental claim status, find a dental provider, view benefits information	www.deltadentalar.com 800-462-5410
VSP	Review vision benefit information, find a vision provider, access claims history	www.vsp.com 800-877-7195
Doctor on Demand (Telemedicine)	Visit a doctor via video from your computer, tablet or smartphone (download the Doctor on Demand app from the App Store or Google Play or text ENROLL to 68398)	www.DoctorOnDemand.com 800-997-6196
Bravo Wellness	Wellness Program, annual health screenings, alternative goals for incentives and appeals	www.bravowell.com/tysonfoods 855-770-9160
Optum (Tobacco Cessation Program)	Tobacco Cessation Program enrollment	www.quitnow.net/TysonFoods 866-784-8454
Advance Medical	Expert Medical Opinion Program	www.advance-medical.net/tysonfoods 888-201-8017
Rethink	Autism and learning disability support program	https://tyson.rethinkbenefits.com 877-988-8871
COBRA Service Center	COBRA eligibility issues, enrollment, billing inquiries	800-643-3410 x6036 (A-L); x6451 (M-Z)

Notice About Other Coverage Options

This booklet only applies to Employees who have elected the Preferred Provider Organization (PPO) option under the Plan and their covered dependents. A different booklet describes the Health Investment Plan option, which is the other medical plan coverage option under the Plan. Employees and dependents who are covered by the Health Investment Plan should consult the Health Investment Plan booklet to determine the terms of their coverage. Other benefits are also described in other booklets that are available under the Plan. If you are unsure which booklet applies to you, please refer to your Benefit Confirmation form or contact your Tyson Benefits Coordinator**.**

Misrepresentations

The Plan reserves the right to pursue all legal and equitable remedies against any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the Plan, submits an application or files a claim containing a false, incomplete, or misleading statement or otherwise provides false, incomplete, or misleading information to the Plan. Such person is subject to discipline up to and including termination of employment. The Plan Sponsor also reserves the right to require that any such person make the Plan whole. Without limiting the generality of the foregoing, if a person who is covered under the Plan (or someone seeking coverage on behalf of a person) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, the Plan reserves the right to rescind (*i.e.*, retroactively cancel) coverage for the covered person.

You May Request a Paper Copy

If you are receiving this document via CD-ROM or electronically, you may request a paper copy from your Benefits Counselor at no charge.

TABLE OF CONTENTS

SUMMARY OF MEDICAL BENEFITS

This section is an outline of the Medical Benefits of the Plan. The sections following this Summary of Benefits describe in detail the benefits and other terms of the Plan.

This Plan includes benefits for preferred providers (hereinafter called In-Network Providers). Your identification card indicates which network of providers applies to your benefits under this Plan. It is important to use In-Network Providers in order to receive the maximum benefits available under the Plan.

Eligibility

Medical Benefits are available for "Full-time" Employees, as defined in Section I of this Plan.

Bargaining unit employees are not eligible to participate in this Plan, unless the terms of their collective bargaining agreement expressly provide otherwise.

Maximum Benefits

Transplant Travel Benefit when rendered by In-Network Transplant Centers (or, in certain circumstances, an In-Network Provider, as described in Section IV Covered Medical Benefits)	
Transportation, Lodging, Meals per transplant	$10,000
Outpatient Chiropractic, Physical Therapy, Occupational Therapy	
Per Individual per Calendar Year	30 combined visits
Outpatient Speech Therapy	
Per Individual per Calendar Year	30 visits
Home Health Care	
Per Individual per Calendar Year	60 visits
Convalescent/Skilled Nursing Facility Services	
Per Individual per Calendar Year	60 days
Long-Term/Acute Care Facility Services	
Per Individual per Calendar Year	60 days
Acute Inpatient Rehabilitation	
Per Individual per Calendar Year	60 days
Neurological Rehabilitation	
Per Individual per Calendar Year	60 days
Fertility Services	
Per Family per Lifetime	1 Smart Cycle

Calendar Year Deductible

Services provided by In-Network Providers:	
Per Individual	$1,100
Per Family	$2,100

Services provided by Out-of-Network Providers:

Per Individual	$1,100
Per Family	$2,100

Copays

Primary care office visits, emergency room services, telemedicine and urgent care office visits are subject to a per visit Copay that must be paid by the covered person. Copay does not apply to Preventive Care Services.

First two Hospital emergency room visits: $100 per visit; after the first two visits: $200 per visit. This Copay is waived when admitted.

$35 per visit for Primary Care Office Visit exam charge when provided by a Physician that is an OB/GYN, a pediatrician, an internist, a family physician, general practitioner, physician assistant, or nurse practitioner.

$20 Copay per visit when accessing a telemedicine physician (by approved telemedicine provider). Including psychologist appointments

$50 Copay per urgent care services that are billed as office visits. If you are treated by an urgent care facility and it is not billed as an office visit, the services are subject to Deductible and Coinsurance.

Calendar Year Out-of-Pocket Maximum

The Medical Benefits Out-of-Pocket Maximum can be met by payments of Coinsurance, Copay and Deductible amounts for Covered Services obtained through In-Network Providers or In-Network Transplant Centers. It cannot be met by non-covered expenses, penalties, or Coinsurance, Copay or Deductible amounts for services obtained from Out-of-Network Providers. The Medical Benefits Out-of-Pocket Maximum is separate from the Prescription Drug Benefits Out-of-Pocket Maximum.

Services provided by In-Network Providers:

Per Individual	$5,000
Per Family	$10,000

Services provided by Out-of-Network Providers: No limit

Inpatient Hospital & Physician Services

	In-Network Providers	Out-of-Network Providers
Medical/Surgical Care Private room Hospital services and supplies	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Failure to obtain pre-certification of an inpatient Hospital admission may result in a reduction of benefits. Refer to the Utilization Review section of this Plan.

Outpatient Hospital & Physician Services

	In-Network Providers	Out-of-Network Providers
Outpatient services - diagnostic	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance
Outpatient services - preventive	Plan pays 100% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Organ and/or Tissue Transplants

You must use In-Network Transplant Centers in order to receive the maximum benefits available under the Plan.

	In-Network Providers	In-Network Transplant Centers	Out-of-Network Providers
Medical/Surgical Care Private room Hospital services and supplies	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance
Transplant Travel Benefit	Not a Covered Expense, unless the particular transplant is not offered by any In-Network Transplant Center. If no In-Network Transplant Center offers the particular transplant, Plan pays 100% up to the Maximum Transplant Travel Benefit.	Plan pays 100% up to the Maximum Transplant Travel Benefit	Not a Covered Expense

Failure to obtain pre-certification of an inpatient Hospital admission may result in a reduction of benefits. Refer to the Utilization Review section of this Plan. The Plan gives you a choice of who provides your care; however, you will be asked to use In-Network Transplant Centers. Refer to the Section IV of this Plan.

Home Health Care

	In-Network Providers	Out-of-Network Providers
Limited to 60 visits per Individual per Calendar Year	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Hospice Care

	In-Network Providers	Out-of-Network Providers
Hospice Care	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Fertility Services

	In-Network Progyny Fertility Providers	Out-of-Network Providers
Limited to one Smart Cycle per Lifetime	After Deductible, Plan pays 80% of Plan Allowance	Not a Covered Expense

Failure to obtain pre-authorization of fertility services may result in a reduction of benefits. The Plan gives you a choice of who provides your care; however, you will be asked to use In-Network Progyny Fertility Providers. Refer to the Section IV of this Plan.

Laboratory and X-ray Services

	In-Network Providers	Out-of-Network Providers
X-ray and lab, including pre-admission testing - diagnostic	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance
X-ray and lab - preventive	Plan pays 100% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Primary Care Office Visit

Copay does not apply to the exam charge for covered Preventive Care Services. Refer to Preventive Care Services below.

	In-Network Providers	Out-of-Network Providers
Exam charge when rendered by OB/GYN, pediatrician, internist, family physician, general practitioner, physician assistant, or nurse practitioner - diagnostic	After $35 Copay, Plan pays 100% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance
Exam charge when rendered by OB/GYN, pediatrician, internist, family physician, general practitioner, physician assistant, or nurse practitioner - preventive	Plan pays 100% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Specialty Office Visit

	In-Network Providers	Out-of-Network Providers
Exam charge when rendered by specialty care providers - diagnostic	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance
Exam charge when rendered by specialty care providers - preventive	Plan pays 100% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Preventive Care Services

A complete list of Preventive Care Services can be accessed at www.hhs.gov. Such services are subject to medical management and other permitted limitations on frequency or scope that the Plan Administrator may impose as described in the other sections of this document.

	In-Network Providers	Out-of-Network Providers
Wellness exam Routine mammogram and pap smear Well child exam Routine immunizations Routine hearing exam Contraceptives	Plan pays 100% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Outpatient Chiropractic, Physical Therapy, Occupational Therapy Services

	In-Network Providers	Out-of-Network Providers
Limited to 30 combined visits per Individual per Calendar Year	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Outpatient Speech Therapy Services

	In-Network Providers	Out-of-Network Providers
Limited to 30 visits per Individual per Calendar Year	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Emergency Department Services

	In-Network Providers	Out-of-Network Providers
Copay waived if admitted	After Deductible and $100 Copay 1st & 2nd visits; $200 Copay for additional visits, Plan pays 80% of Plan Allowance	After Deductible and $100 Copay 1st & 2nd visits; $200 Copay for additional visits, Plan pays 50% of Plan Allowance

Convalescent/Skilled Nursing Facility Services

	In-Network Providers	Out-of-Network Providers
Limited to 60 days per Individual per Calendar Year	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Acute Inpatient Rehabilitation/Neurological Rehabilitation Services

	In-Network Providers	Out-of-Network Providers
Limited to 60 days per Individual per Calendar Year	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Long-Term/Acute Care Facility Services

	In-Network Providers	Out-of-Network Providers
Limited to 60 days per Individual per Calendar Year	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

Durable Medical Equipment and Supplies, Prosthetic and Orthotic Devices

	In-Network Providers	Out-of-Network Providers
Durable Medical Equipment and supplies, prosthetic and orthotic devices	After Deductible, Plan pays 80% of Plan Allowance	After Deductible, Plan pays 50% of Plan Allowance

SUMMARY OF PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits become available at the same time as Medical Benefits for eligible Employees and their eligible Dependents. Benefits are provided through the CVS Caremark Network. It is important to use Tier 1 Retail Pharmacies within the CVS Caremark Network in order to receive the maximum benefits available under the Plan.

Tier 1 Retail Pharmacies: CVS retail pharmacy, Kroger, Harps, Walmart, Hy-Vee, DIELRX and their subsidiaries
Tier 2 Retail Pharmacies: All other CVS Caremark Network Pharmacies

Lifetime Maximum Benefits

Fertility Drugs with Medical Diagnosis (through Mail Order only)	$5,000

Calendar Year Out-of-Pocket Maximum

Prescription Drugs obtained through CVS Caremark Network Pharmacies:

Per Individual	$2,150
Per Family	$4,300

The Prescription Drug Benefits Out-of-Pocket Maximum can be met by payments of Coinsurance and Copay amounts for Prescription Drugs obtained through CVS Caremark Network Pharmacies. It cannot be met by non-covered expenses, penalties, or Coinsurance and Deductible amounts for Prescription Drugs obtained through Non-Network Pharmacies. The Prescription Drug Benefits Out-of-Pocket Maximum is separate from the Medical Benefits Out-of-Pocket Maximum.

Calendar Year Deductible

There is no Deductible for Prescription Drugs obtained through the CVS Caremark Network.

Prescription Drugs obtained through pharmacies other than the CVS Caremark Network:

Per Individual	$50

Copays

For Prescription Drugs obtained through the CVS Caremark Specialty Pharmacy (Up to a 30-day supply):

Generic	$75
Preferred Brand	$100
Non-Preferred Brand	$125

Refer to the Covered Prescription Drug Benefits section for details about copay assistance programs offered by third party specialty medication manufacturers which may reduce your cost.

For Prescription Drugs obtained through a CVS Caremark Network Pharmacy:

Tier 1 Retail Pharmacies (up to a 30-day supply)	**You pay…**	**With a minimum payment of…**	**With a maximum payment of…**
Select Generic* & Select Preventive**	Nothing	$0	$0
Generic	20% of the Network Pharmacy price	$10	$20
Preferred Brand***	20% of the Network Pharmacy price	$30	$60
Non-Preferred Brand***	20% of the Network Pharmacy price	$135	$240
Tier 2 Retail Pharmacies (up to a 30-day supply)	**You pay…**	**With a minimum payment of…**	**With a maximum payment of…**
Generic	30% of the Network Pharmacy price	$20	$40
Preferred Brand***	30% of the Network Pharmacy price	$60	$120
Non-Preferred Brand***	30% of the Network Pharmacy price	$200	$360
Maintenance Choice® (up to a 90-day supply)	**You pay…**	**With a minimum payment of…**	**With a maximum payment of…**
Select Generic* & Select Preventive**	Nothing	$0	$0
Generic	20% of the Network Pharmacy price	$20	$40
Preferred Brand***	20% of the Network Pharmacy price	$60	$150
Non-Preferred Brand***	20% of the Network Pharmacy price	$270	$485

* Select Generic medications are long-term “maintenance” medications identified by the Plan Sponsor as having a $0 Copay. When they are obtained through Kroger, Harps, Walmart, DIELRX, or Hy-Vee retail pharmacies or the CVS Caremark Maintenance Choice Program, there are no refill limits. If a Select Generic medication is obtained through any other CVS Caremark Network Pharmacy, it is subject to the long-term maintenance medication refill limits.

** Select Preventive medications are selected generic, single-source brand, and over-the-counter medications identified by the Plan Administrator that, when obtained with a prescription, have a $0 Copay. A list of the types of medications that are Select Preventive medications is available on the Plan Sponsor’s intranet site or from the Plan Administrator and is updated periodically. If you have a specific question about whether your medication is a Select Preventive medication, you should contact the Claims Administrator. Consistent with medical management techniques permitted by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), as amended, not all preventive medications are Select Preventive medications and age requirements and/or quantity limits will apply to certain Select Preventive medications.

*** If a brand name drug is dispensed when a generic equivalent (that is, a generic with the same active chemical compound as the brand drug) is available, you will be required to pay the difference in the cost of the drugs in addition to the higher brand Copay as a penalty unless the brand name drug is determined to be Medically Necessary for you as determined by the Claims Administrator. Penalties do not apply toward the Deductible or Out-of-Pocket Maximum. Whether a brand name drug is preferred or

non-preferred is determined in accordance with the policies and procedures established by the Plan Administrator. In addition, to ensure that you are receiving the most cost-effective drug to treat your condition, you may be required to go through step therapy or obtain prior authorization if a more cost-effective alternative is available. A cost-effective alternative may include a generic or brand drug that is intended to treat the same condition as the drug you have been prescribed, even though it is not the same chemical compound. If you do not meet the criteria of the step therapy or prior authorization programs for specified drugs identified by the Plan Administrator, the Plan will not pay for any portion of the cost for the drug. In step therapy, you must have previously tried an alternative drug. If you have not tried an alternative, your doctor may contact Caremark to obtain prior authorization. If the criteria are met, and the prior authorization is approved, the Plan will pay its portion of the cost for the drug.

Tier 1 Retail Pharmacy and Tier 2 Retail Pharmacy Pricing

If you do not have a Tier 1 Retail Pharmacy within an average of three miles of your home zip code in urban markets, five miles in suburban markets and 13 miles in rural markets, in each case, as determined by the Plan Administrator, you will be considered "out-of-area." If you are considered out-of-area for Prescription Drug benefit purposes, you may go to any Tier 2 Retail Pharmacy and receive the same benefits as you would for a Tier 1 Retail Pharmacy for up to a 30-day supply. Out-of-area participants must get more than a 30-day supply filled through the CVS Caremark Mail Order program. The determination of whether you are considered out-of-area will be made periodically by the Plan Administrator and updated from time to time. You may contact the Claims Administrator to determine if you are considered out-of-area.

For Prescription Drugs obtained through pharmacies other than a CVS Caremark Network Pharmacy:

After Deductible, you pay 50% of the equivalent Network Pharmacy price, plus the difference between the Network Pharmacy price and the Non-Network Pharmacy price.

Retail and Specialty Pharmacy Prescription Drugs are normally dispensed for up to a 30-day supply on single orders; mail order Prescription Drugs are normally dispensed for up to a 90-day supply. However, if a prescription is submitted for a supply less than the normal supply, the full Copay is applied. Under the Maintenance Choice Program, you can purchase up to a 90-day supply of your Prescription Drugs when filled at a CVS retail pharmacy or through the Mail Order Program, excluding drugs obtained through the CVS Caremark Specialty Pharmacy. You will pay the Mail Order Copay instead of the Retail Copay for drugs purchased through the Maintenance Choice Program.

Except as described above, long-term "maintenance" medications must be purchased through Kroger, Harps, Walmart, DIELRX or Hy-Vee retail pharmacies or the CVS Caremark Maintenance Choice Program. These medications are limited to one (1) initial fill and one (1) refill through any other retail pharmacy. Examples include medications for managing high blood pressure, asthma, diabetes and high cholesterol.

SUMMARY OF DENTAL BENEFITS

You and your eligible Dependents are eligible for Dental Benefits upon enrollment in the Medical Benefits portion of the Plan. You will be automatically enrolled in the Dental Core Plan upon enrollment in the Medical Benefits portion of the Plan, unless you timely elect the Dental Buy-Up Plan option. Your type of Dental Benefits coverage is determined based upon your Medical Benefits selection (e.g., Team Member Only/Team Member + 3 Children). If you choose the Dental Buy-Up Plan, you are required to maintain coverage in the Dental Buy-Up Plan for at least a continuous two (2) year period.

The dental network through Delta Dental is a passive network, so you can use any dental provider you choose and still receive coverage. However, if you use a Delta Dental provider, you will receive Covered Expenses at a discounted rate. In addition, Delta Dental providers will not balance bill for any difference between the billed charge and the Network Fee Schedule amount.

The Plan pays up to the Network Fee Schedule for Covered Expenses.

Calendar Year Deductible

Core Plan

Basic Dental Services per Individual:	$50

Buy-Up Plan

Basic Dental Services and Major Dental Services per Individual:	$50

There is no Deductible for Preventive and Diagnostic Dental Services.

Calendar Year Maximum Benefit

Core Plan

Per Individual per Calendar Year	$500

Buy-Up Plan

Per Individual per Calendar Year	$1,500

Preventive and Diagnostic Dental Services

The Plan pays 100% of the Network Fee Schedule.

Basic Dental Services

After Deductible, the Plan pays 80% of the Network Fee Schedule.

Major Dental Services

Core Plan

Not a Covered Expense.

Buy-Up Plan

After Deductible, the Plan pays 50% of the Network Fee Schedule.

Orthodontic Dental Services

Core Plan

Not a Covered Expense.

Buy-Up Plan

The Plan pays 50% of the Network Fee Schedule up to a $1,500 Lifetime Maximum Benefit for Dependent children under age 19 only. This Lifetime Maximum Benefit is separate from the calendar year maximum benefit. If you previously met a lifetime maximum benefit limit for orthodontic dental services under this Plan or a prior plan maintained by the Plan Sponsor, then no additional benefits will be paid for orthodontic dental services under the Buy-Up Plan.

SUMMARY OF VISION BENEFITS

You and your eligible Dependents are eligible for Vision Benefits upon enrollment in the Medical Benefits portion of the Plan. You will be automatically enrolled in the Vision Core Plan (based on your Medical Benefits election) upon enrollment in the Medical Benefits portion of the Plan, unless you timely elect the Vision Buy-Up Plan option. Your type of Vision Benefits coverage is determined based upon your Medical Benefits selection (e.g., Team Member Only/Team Member + 3 Children).

Vision Benefits are provided through VSP. It is important to use the VSP network of providers in order to receive the maximum benefits available under the Plan. However, through the VSP Open Access network, you can use your vision benefit at any Eyecare Provider. Ask your Eyecare Provider if they will accept direct payment from VSP. If so, have them contact VSP at 800-877-7195. The provider will obtain your benefit information, collect the necessary Copay and any balance above your Open Access schedule of allowances. They can then submit the claim on your behalf to VSP. This means you do not need to pay the entire bill up front and submit a statement to VSP for reimbursement. If you do not use a VSP Provider, your benefit is reduced.

Calendar Year Deductible

There is no Deductible for Vision Benefits.

Vision Services

PLAN SUMMARY	CORE PLAN	BUY-UP PLAN
Description	**Copays and Allowances with VSP Providers**	
Exam:		
Well Vision Exam Copay	$25	$20
Well Vision Exam ..... Covered once every	12 months	12 months
Prescription Glasses:		
Lenses and Frames ..... Covered once every	24 months	12 months
Standard Lenses Copay • Single vision, lined bi-focal and lined tri-focal lenses • Polycarbonate lenses for dependent children	$25	$25
Lens Enhancements Copay		
• Standard progressive lenses	$50	$50
• Premium progressive lenses	$80-$90	$80-$90
• Custom progressive lenses	$120-$160	$120-$160
Frames Allowance ..... Covered up to • Plus, 20% off any out-of-pocket costs • If frames are purchased without lenses, the Standard Lens Copay is deducted from the allowance.	$75	$200
****OR****		

Contact Lenses	**Covered once every**	24 months	12 months
Lens Copay		$25	$0
Lens Allowance.....	**Covered up to**	$75	$200
• When you choose contacts instead of glasses, your allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit.			
• The Copay is deducted from the allowance.			

Open Access Reimbursement Allowances		**Coverage with Non-VSP Providers**	
Exam.....	**Covered up to**	$50	$50
Single Vision Lenses.....	**Covered up to**	$50	$50
Bifocal Lenses	**Covered up to**	$75	$75
Trifocal Lenses	**Covered up to**	$100	$100
Frames.....	**Covered up to**	$60	$70
Contact Lenses.....	**Covered up to**	$60	$105

SECTION I. ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

A. Eligibility and Effective Date

1. Who Is Eligible

You are eligible to participate in the Plan if you are a Full-time Employee of the Plan Sponsor or an affiliate which has adopted the Plan and you are a member of an eligible class of Employees. You are not in an eligible class if you are classified as a part-time Employee, are classified as a seasonal Employee (even if you are designated as full-time or work an average of thirty (30) or more hours per week), or belong to a class that is not designated for participation in the Plan. "Employee" means any common law employee of the Plan Sponsor or any affiliate which has adopted the Plan. "Employee" does not include any person who is classified by the Plan Sponsor or an affiliate as an independent contractor for federal income tax purposes for any period, regardless of any subsequent determination that such person should have been characterized as a common law employee of the Plan Sponsor or an affiliate for the period in question. "Full-time" means you either (a) are designated as "full-time" on the records of the Plan Sponsor or (b) are determined, pursuant to the Plan Sponsor's policies and procedures, to work at least an average of thirty (30) hours per week over a 12-month measurement period designated by the Plan Sponsor. If you are enrolled in the Plan, you are a "covered Employee" or a "covered person."

Bargaining unit employees are not eligible to participate in this Plan, unless the terms of their collective bargaining agreement expressly provide otherwise.

2. Effective Date of Coverage for the Medical, Dental, Vision and Prescription Drug Benefits

If you are a newly eligible Employee who is designated as "full-time" on the record of the Plan Sponsor, you may become covered for the Medical, Dental, Vision and Prescription Drug Benefits on the first day of the calendar month following completion of fifty-nine (59) days of continuous Full-time employment. However, this waiting period may not apply to you if you terminate employment and are reinstated and your service is bridged under the Plan Sponsor's applicable employment policies. If you are a newly hired Employee not designated as "full-time" on the records of the Plan Sponsor when you are hired, but you work a variable or seasonal schedule, you may become covered no later than the first day of the second month that begins after the first anniversary of your hire date if you are determined to work an average of at least 30 hours per week over a designated 12-month measurement period following your date of hire.

If you fail to submit a completed enrollment form on a timely basis before the effective date of coverage for Medical Benefits, you will automatically be enrolled with Team Member Only coverage. If you are an eligible Employee, you can waive automatic enrollment only if you are covered under other health coverage that qualifies as "minimum essential coverage" under the Affordable Care Act and constitutes "creditable coverage" under the Health Insurance Portability and Accountability Act of 1996 and submit appropriate verification of such coverage. If you are unsure whether your health coverage constitutes minimum essential coverage or creditable coverage, contact your insurer or other health coverage provider and request documentation.

If you are a Full-time Employee who is enrolling during a regular open enrollment period, you must submit a completed enrollment form on a timely basis before the end of the open enrollment period in the time and manner required pursuant to the policies and procedures adopted by the Plan Administrator. Your effective date of coverage is the first day of the next calendar year. If you work a variable or seasonal schedule, then to be eligible for coverage you must average 30 hours per week over a 12-month measurement period designated by the Plan Sponsor from year to year for ongoing employees in accordance with the Plan Sponsor's policies and procedures.

The cost of coverage under the Plan for you (and any eligible Dependents, if applicable) will be paid in substantially equal installments through payroll deductions on a before-tax basis to the extent available.

The Plan Sponsor provides its covered Employees and their covered spouses with an opportunity to participate in a wellness incentive program (the Wellness Program). The Wellness Program includes financial impacts on employee health plan premium contributions if you and your spouse, if applicable, qualify for certain pre-determined goals and criteria. The financial impacts are communicated to you prior to your effective date of coverage and at each open enrollment.

By meeting various requirements or completing appropriate alternative standards under the Wellness Program, participants can qualify for a lower payroll deduction for the Medical Benefits under the Plan than the payroll deduction applied to a non-participant. Program participants may also be given opportunities to access health improvement resources and benefits designed to improve their overall health status.

First, if you have not used tobacco or nicotine products within ninety (90) days prior to your effective date of coverage, you will be entitled to the non-tobacco user incentive. You will be asked to provide evidence that you have not used tobacco or nicotine products in the manner designated by the Plan Administrator, which may vary based on classes of employees or other criteria that the Plan Administrator determines are appropriate. The non-tobacco user incentive allows you to pay less for your coverage under the Plan than a similarly situated tobacco or nicotine user. Or, if you are a tobacco or nicotine user, you can also qualify for the non-tobacco user incentive if you enroll in the Tobacco Cessation Program by the deadline designated by the Plan Administrator, and complete the program within ten (10) weeks of your enrollment in the program. Upon timely enrollment and completion of the program, you are entitled to receive the non-tobacco user incentive retroactive to your effective date of coverage.

If you are a tobacco or nicotine user and it is medically inadvisable or unreasonably difficult due to a medical condition for you to stop using tobacco or nicotine, then you may request that the Plan Administrator allow you to earn the non-tobacco user incentive using an alternative method or standard. Additionally, if you are not a tobacco or nicotine user, but you are not receiving the non-tobacco user incentive (for example, because you were required to certify that you did not use tobacco or nicotine and failed to do so), you are not eligible for the Tobacco Cessation Program. In that case, you may request that the Plan Administrator allow you to use the non-tobacco user incentive using an alternative method or standard as permitted by the Plan Administrator. The amount of the non-tobacco user incentive is set by the Plan Sponsor from year to year. If you certify that you have not used tobacco and it is later determined that your certification is false, you will no longer be entitled to the non-tobacco user incentive and you may be required to pay the additional amount on an after-tax basis. The Plan Administrator may, in its discretion, impose such additional charge retroactively to the date it determines that your certification was false. The Plan Administrator reserves the right to require a lab test to confirm whether or not your certification is true.

The Wellness Program also requires an annual health screening. The screenings are generally offered on-site and are provided at no cost to eligible employees. Individual test results are not shared with the Plan Sponsor and are limited to entities that are permitted to receive Protected Health Information (PHI).

Generally, the value of the incentives earned is determined by the results of the health screening conducted. If you are unable to meet a goal under this Wellness Program, you might qualify to earn the same financial incentive by different means. Although voluntary, if you choose not to participate, you will pay more for your health coverage. We will work with you (and, if you wish,

with your Physician) to find an alternative with the same reward that is right for you in light of your health status. Participants must be actively employed and still enrolled in the plan to earn credit.

Participants should refer to Wellness Program communications for additional details regarding the Wellness Program. Helpful documents include the Program Participant Guide.

There is an appeal process for each goal. The results of a health assessment do not necessarily preclude a participant from obtaining the incentive under this Wellness Program. Claims are handled by the Claims Administrator in accordance with the Plan's claims procedures.

The Plan Administrator may make available such other wellness or health promotion programs as it deems advisable from time to time, which may include participation-only or outcomes-based programs. You will be notified of any such programs that apply to you in other communications provided by the Plan Administrator.

3. **Coverage For Your Dependents**

Eligible Dependents are your spouse and your children up to age 26.

The term "spouse" means an individual whose marriage to you is (a) evidenced by a license issued by an appropriate governmental authority of the jurisdiction in which your marriage took place; or (b) recognized as a common law marriage by the laws of the state where you reside, but only if the marriage is also evidenced with filing by the couple of the most recently due Federal Income Tax return under the status of "married filing jointly" or "married filing separately" or such other evidence acceptable to the Plan Administrator. Your spouse continues to be eligible for so long as you are married to him or her, even if you are legally separated from him or her. Unless you certify that your spouse is not eligible for coverage under his or her employer's plan, you will be required to pay a spousal surcharge to cover your spouse under the Plan. The amount of the spousal surcharge is set by the Plan Sponsor from year to year. If you certify, in the manner designated by the Plan Administrator, that your spouse is not eligible for coverage under his or her employer's plan, you will not be charged the spousal surcharge. If it is later determined that your certification is false, you will have the spousal surcharge applied to your coverage and you may be required to pay the surcharge on an after-tax basis. The Plan Administrator may, in its discretion, impose such surcharge retroactively to the date it determines that your certification was false. If your spouse is covered under the Plan, you are required to inform the Plan Administrator of any changes in your spouse's eligibility for coverage under another employer's plan.

The term "children" means your natural children or:

(a) step children;
(b) legally adopted children, including children placed with you for the purpose of adoption;
(c) children for whom permanent legal guardianship can be shown.

Adopted children are deemed to be acquired on the date of placement with you for the purpose of adoption. You must enroll your adopted children within two (2) months of the date of adoption or date of placement, whichever is earlier.

Eligible Dependent children do not include grandchildren, nieces, nephews, or any other children related by blood or marriage unless legally adopted or for whom legal guardianship can be shown, with such documentation as is acceptable to the Plan Administrator. In addition, eligible Dependent children do not include your natural or adopted child if you have given up your parental rights to that child.

An unmarried child of any age who is physically or mentally incapable of self-support, and who was your covered Dependent prior to reaching age 26 at the time he or she became incapacitated, may be covered as an eligible Dependent. This is subject to proof of incapacity and the provisions under "Termination of Coverage" on a following page.

If both husband and wife are covered under the Plan as Employees, either, but not both, may elect to cover the eligible Dependents of both. Employees cannot be covered as both an Employee and a spouse or Dependent child of an Employee, i.e., double coverage is not permitted.

If you and your former spouse are covered under the Plan as Employees, either or both, may elect to cover eligible Dependents.

If you have an eligible Dependent or Dependents and elect to cover them, the benefits with respect to your Dependents will become effective on the date you become covered, unless Team Member Only coverage was already in effect for you. If you wish to cover any Dependent over six months old, you must provide appropriate documentation, including his or her Social Security card. Each eligible Dependent enrolled in the Plan is also a "covered person."

4. **If You Do Not Enroll Yourself or Your Dependents On Time**

You should apply for coverage for yourself and your Dependents when first eligible. If you do not, you and/or your Dependents will be late enrollees. As late enrollees, you and/or your Dependents will only be permitted to apply for coverage:

(1) at the next open enrollment, or

(2) within two (2) months of one of the following special changes:

(a) if you did not enroll yourself or your Dependents under this Plan because you or your Dependents were covered under another group health plan or other health insurance coverage provided by a health insurance issuer (including coverage obtained through or outside of a health insurance marketplace/exchange) and one of the following has occurred:

(i) coverage was terminated as a result of loss of eligibility for the coverage (for example, due to legal separation, divorce, death, termination of employment, or reduction in hours);

(ii) coverage was under a COBRA continuation or similar state law provision and coverage has been exhausted; or

(iii) the employer contributions of the other group health plan were terminated (other than COBRA continuation coverage;

If you lose coverage for one of the reasons described in (a)(i) through (iii) above, you may enroll yourself and any of your eligible Dependents. If one of your eligible Dependents loses coverage for one of the reasons described in (a)(i) through (iii) above, you may only enroll the affected eligible Dependent (although you must already be enrolled to enroll the affected eligible Dependent). Coverage for you and your Dependents who enroll for a reason described in (a)(i) through (iii) above will become effective on the day of the month the enrollment form is delivered in satisfactory form to the Benefits Department. **Note:** A loss of eligibility under another plan or other health insurance coverage does not include a voluntary termination of coverage, a loss because premiums were not paid in time, or termination of coverage because of fraud or a material misrepresentation.

or

(b) if you acquire an eligible:

(i) spouse through marriage;
(ii) newborn; or
(iii) child up to age 26 through adoption or who has been placed with you for the purpose of adoption.

Under any of the circumstances described in (b)(i) through (iii) above, you may enroll yourself and/or your spouse, if you and/or your spouse are not already enrolled. You may also enroll any non-spouse Dependent who becomes a Dependent as a result of the marriage, birth, adoption, or placement for adoption. However, to enroll your spouse or other Dependent, you must either already be enrolled or enroll with your spouse and/or other Dependent at the same time.

As late enrollees, you and your Dependents' coverage will become effective on the day of the event and if you enroll yourself and/or your Dependents because of a special change as described in (b)(i) through (iii) above, the coverage will become effective:

(1) on the date the Plan Administrator is notified of marriage, if notified timely;
(2) retroactive to the date of birth of a newborn; or
(3) retroactive to the date of placement of a child for the purpose of adoption.

or

(c) if you or one of your Dependents:

(i) loses coverage under a Medicaid Plan or a State child health plan under Title XXI of the Social Security Act; or
(ii) becomes eligible for premium assistance through Medicaid or a State child health plan under Title XXI of the Social Security Act to help pay premiums under this Plan.

Under the circumstances described in (c)(i) and (ii) above, you may only enroll the person or persons who lose coverage or become eligible for premium assistance, as applicable (although you must enroll yourself or already be enrolled to enroll an affected eligible Dependent). Coverage will become effective on the day of the month the enrollment form is delivered in satisfactory form to the Benefits Department.

In connection with the special change in (a), (b), or (c) above, you may change your election from PPO coverage to Health Investment Plan coverage (the other medical plan coverage option available under the Plan)or from Health Investment Plan to PPO. For example, if you are enrolled in PPO coverage and get married, you could elect Health Investment Plan coverage for you and your spouse instead. However, the only other time you may switch between Health Investment Plan and PPO coverage is at open enrollment.

In addition, if a Qualified Medical Child Support Order (QMCSO) is received within two (2) months of the notification date the child will be enrolled in accordance with the terms of the QMCSO. If the Plan Administrator is not notified timely, coverage will be denied and your Dependent cannot be added until the next open enrollment. A QMCSO is a court or state agency order, usually issued as part of a settlement agreement or divorce decree, that provides for child support or health care coverage for your child. (See Section XIII for further details of QMCSO.)

5. **Changes in Status**

IMPORTANT: Once you (and your Dependents, if applicable) are enrolled in the Plan, you may not change your coverage (e.g., Team Member Only/Team Member + Spouse) until the open enrollment period, unless you have (or the applicable Dependent has) a Change in Status. A Change in Status entitles you to change your coverage election.

The term "Change in Status" is a change which affects you due to (1) your marriage or divorce; (2) the death of your spouse or a Dependent child; (3) the birth, adoption or placement for adoption of a child; (4) a change in employment status affecting you, your spouse or a Dependent child; (5) commencement or termination of legal guardianship of a child; (6) a child reaching the maximum age and is no longer eligible as a Dependent under the Plan; (7) taking or returning from an unpaid leave of absence by you, your spouse, or your Dependent child which results in a loss of coverage; (8) a judgment, decree, or order that requires or permits you to cover, or not to cover, a Dependent child under the Plan; (9) you or your Dependent becoming eligible for Medicare or Medicaid; (10) you or your Dependent losing coverage for Medicare or Medicaid; or (11) any other event that would qualify as a "Change in Status" under the Tyson Foods, Inc. Cafeteria Plan.

In order to make a new coverage election, the change in coverage must be on account of and consistent with the Change in Status. Written notification of a Change in Status must be made within two (2) months, except changes due to a loss of coverage during a leave of absence must be made within thirty-one (31) days of the return. Evidence of a Change in Status may also be requested. However, you may not switch between PPO and Health Investment Plan coverage as a result of a Change in Status unless it is also a special change that would allow you to enroll yourself or your dependents as described above under "If You Do Not Enroll Yourself or Your Dependents On Time."

Additionally, if you elect coverage for Dental Benefits under the Buy-Up Plan, which requires you to be covered for a minimum continuous period of two (2) years following the effective date of your coverage, then your ability to make a change in election due to a Change in Status will be limited during that continuous two (2) year period. Specifically, if you have an event that otherwise qualifies as a Change in Status during that continuous two (2) year period, you may only change your election for coverage under the Buy-Up Plan to:

(1) add a Dependent to or remove a Dependent from the Buy-Up Plan;

(2) eliminate such coverage, but only if you elect to cease all coverage under the Plan (including medical and vision).

This restriction shall not apply after the expiration of such continuous two (2) year period.

6. **Reporting Changes in Eligibility**

Any change in your or your Dependents' eligibility must be reported to the Plan Sponsor within two (2) months, whether or not it results in a classification and/or contribution change. If a Dependent is not specifically named on your enrollment form, the Dependent will not be covered. If you wish to cover any Dependent over six months old, you must provide appropriate documentation, including their Social Security card.

B. Termination of Coverage

1. Your coverage will terminate on the earliest of the following dates, with your last minute of coverage beginning at 11:59 p.m. Central Time on such date:

   (a) the date the Plan is terminated;
   (b) the date the Plan is amended to terminate the coverage of a class of Employees of which you are a member;
   (c) with respect to any benefits for which you cease to be a member of the class or classes of Employees eligible for such benefits, the day such cessation occurs;
   (d) the date ending the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due;
   (e) the day you cease to be a Full-time Employee;
   (f) the day your employment is terminated;
   (g) the date you retire; or
   (h) if you are determined to work an average of 30 hours per week over the designated 12-month period following your date of hire, your coverage terminates on the first anniversary of your effective date of coverage unless you are otherwise eligible for coverage on that date.

   Your coverage may also be terminated retroactively (i.e., rescinded) if you (or someone seeking coverage on your behalf) performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact.

2. Your coverage with respect to Dependents will terminate on the earliest of the following dates, with your last minute of coverage beginning at 11:59 p.m. Central Time on such date:

   (a) the date ending the period for which your last contribution is made, if you fail to make any required contribution towards the cost of benefits for your Dependents when due;
   (b) the date your coverage is terminated;
   (c) the date a Dependent child ceases to be eligible as a Dependent because of reaching age 26, except as shown below, or otherwise ceasing to qualify as an Eligible Dependent; or
   (d) the date that adoption proceedings are discontinued provided that such proceedings do not result in finalization of the adoption.

   Coverage may be continued for a Dependent after age 26 who has become mentally or physically incapable of earning a living prior to age 26 provided you furnish evidence of the Dependent's incapacity.

   Any coverage continued for such a Dependent child will terminate under any of the conditions described above, or, in any event, when the Dependent ceases to be incapacitated.

   Your Dependent's coverage may also be terminated retroactively (i.e., rescinded) if your Dependent (or someone seeking coverage on his or her behalf, including, for example, you) performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact.

C. Continuation of Coverage

1. **Family and Medical Leave Act of 1993**

   You may continue your coverage and coverage for your Dependents during a leave of absence in accordance with the Family and Medical Leave Act of 1993 ("FMLA leave").

If you continue such coverage during an FMLA leave:

(a) any contributions required of you must continue to be paid;
(b) any change in benefits that occurs during the period of continuation will apply on the effective date of the change; and
(c) the continuation during an FMLA leave will run concurrently with a continuation during any other leave of absence.

If you do not continue your coverage and your Dependents' coverage during an FMLA leave you and your Dependents will be covered on the day of the month you return to work from the leave, subject to the Plan Sponsor's FMLA leave policy then in effect. For this to happen, you must return to work immediately after the FMLA leave ends.

Note: Entitlement to FMLA leave does not constitute a qualifying event for the purposes of COBRA continuation. However, a person entitled to COBRA continuation as a result of not returning to active employment following FMLA leave may be entitled to COBRA continuation coverage, the duration of which will be calculated from the date the person fails to return from the FMLA leave.

2. **Lay-off or Leave of Absence**

Your coverage under the Plan may be continued for up to 6 months (with premium payment) for an approved lay-off or leave of absence in accordance with the Plan Sponsor's policies then in effect.

After you have returned to active work from an approved lay-off or leave of absence, you will be eligible to continue your coverage, subject to the lay-off or leave of absence policy of the Plan Sponsor then in effect. If you go on another leave of absence without being back at work for 30 calendar days, your return will be disregarded and your continuation coverage time will be calculated based from the first or previous leave of absence.

3. **Uniform Services Employment and Reemployment Rights Act of 1994**

You may continue your coverage and coverage for your Dependents during military leave of absence in accordance with the Plan Sponsor's military leave policy.

If you continue such coverage during such leave:

(a) any contributions required of you must continue to be paid;
(b) any changes in benefits that occur during the period of continuation will apply on the effective date of the change;
(c) the continuation during military leave will run concurrent with a continuation during any other leave of absence, except as otherwise provided in the Plan Sponsor's leave of absence policy or except for COBRA which is described in Section XII.

Coverage may be continued until the earlier of:

(a) 24 months; or
(b) the day after you fail to return to work as outlined by the Plan Sponsor's military leave policy.

If you do not continue your coverage and your Dependent's coverage during such leave and you return to work, you and your Dependents will be covered on the date you return to work from the leave. For this to happen, you must return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994.

D. Extended Benefits

There Are No Extended Medical, Dental, Vision Or Prescription Drug Benefits After Coverage Ends.

SECTION II. UTILIZATION REVIEW AND CASE MANAGEMENT PROGRAMS

This Section describes the Utilization Review Services and Case Management Services programs related to Medical Benefits.

A. Utilization Review Services Program

Utilization review is a program designed to promote access for you and your family to necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Pre-certification of the Medical Necessity for Non-Emergency Hospital Admission or an admission to a Convalescent/Skilled Nursing Facility, Neurologic Rehabilitation Facility, or Residential Treatment facility;
(b) Retrospective review of the Medical Necessity for hospitalizations provided on the basis of an Emergency Illness or Emergency Injury;
(c) Concurrent review, based on the admitting diagnosis, for hospitalizations requested by the attending Physician;
(d) Certification of services and planning for discharge from a Hospital or cessation of medical treatment;
(e) Pre-certification of outpatient radiological imaging services, such as Magnetic Resonance Angiography or Imaging ("MRA/MRI"), Computed Tomography Scanning ("CT Scan"), Nuclear Cardiology, Echo Cardiography and positron emission tomography scans ("PET Scan"), collectively referred to as "Advanced Diagnostic Imaging";
(f) Pre-certification of Applied Behavioral Analysis (ABA) therapy; and
(g) Pre-certification of medical or radiation oncology services, including but not limited to chemotherapy, brachytherapy, proton beam therapy, and 3D conformal.

The attending Physician is not required to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. Any longer hospitalizations, however, still require pre-certification.

In order to maximize Plan reimbursements, please read the following provisions carefully.

1. How The Program Works

Pre-certification. Before a Non-Emergency Hospital Admission or an admission to a Convalescent/ Skilled Nursing Facility, Neurologic Rehabilitation Facility, or Residential Treatment facility, the Plan requires that the Physician or a representative of the Hospital or applicable facility first call the Plan's pre-certification service and obtain pre-certification of the Medical Necessity of the hospitalization.

The pre-certification process is set in motion by a telephone call from the admitting Physician/ Hospital/facility. For any Non-Emergency Hospital Admission or an admission to a Convalescent/ Skilled Nursing Facility, Neurologic Rehabilitation Facility, or Residential Treatment facility, you should ask the Hospital, facility, or the admitting Physician to contact the Claims Administrator at the pre-certification services telephone number on your member identification card **at least 24 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the Employee
- The name, address and member identification number of the Employee
- The name of the Plan

- The name and telephone number of the attending/admitting Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an **Emergency Hospital Admission**, the patient, patient's family member, Hospital or attending Physician must contact the Claims Administrator **within 48 hours** of the first business day after the admission.

Based on information available from the Hospital, facility, and/or your Physician, the pre-certification process evaluates whether your medical condition and overall circumstances show that admission to the Hospital or other requested facility is Medically Necessary and meets the Claims Administrator's coverage criteria. If it is not Medically Necessary to admit you to the Hospital or requested facility – in other words, if appropriate care and treatment can be provided to you in an alternative setting outside the Hospital or requested facility – pre-certification will be denied and the Plan will not cover any charges for your hospitalization or stay in the applicable facility.

A pre-certification approval does not mean that the Plan will cover the Hospital or facility admission and related charges. The Hospital or facility admission must meet all other terms and conditions of the Plan and the Claims Administrator's coverage criteria to be covered. A pre-certification approval only confirms that, based on the information furnished to the Plan or its Claims Administrator, admission to the Hospital or requested facility was Medically Necessary and met the Claims Administrator's applicable coverage criteria on the date of admission, and for the number of days (if any) stated in the pre-certification notice. If pre-certification is given for a hospitalization or stay in a facility, the Plan or its Claims Administrator still may deny coverage for the hospitalization or facility stay based on other terms and conditions of the Plan. By way of example only, such other terms and conditions may include such things as whether you remain eligible for benefits under the Plan on the date of Hospital or facility admission, whether all premiums have been paid, whether any other specific exclusions or limitations listed in the Plan apply and whether the Hospital, facility, or applicable providers are In-Network Providers.

The Plan always requires Medical Necessity as a pre-condition to coverage for any Hospital, Convalescent/Skilled Nursing Facility, Neurologic Rehabilitation Facility, or Residential Treatment Facility admission; in other words, regardless of any other factors, and regardless of whether or not pre-certification is or is not obtained, the Plan will not pay any benefits for any Hospital, Convalescent/Skilled Nursing Facility, Neurologic Rehabilitation Facility, or Residential Treatment Facility admission unless it is Medically Necessary.

In addition, however, the Plan has established certain financial consequences for failing to obtain pre-certification for Hospital admissions as follows:

- **Hospitals In Arkansas**: If pre-certification is not obtained for a Non-Emergency Hospital Admission in the state of Arkansas to an In-Network Hospital, the Plan will deny all benefits for such admission but the responsibility for the cost of the admission will fall on the In-Network Hospital that failed to obtain pre-certification, and you should not be billed for any charges for the admission because the Hospital, as an In-Network Provider, is obligated not to bill you for such charges. If you utilize an Out-of-Network Hospital in the state of Arkansas that fails to obtain pre-certification for your Hospital admission, the Plan will not deny benefits for such services based solely on the failure of the Out-of-Network Hospital to obtain pre-certification; however, you might also be held responsible by the Out-of-Network Hospital for paying the difference between the Plan Allowance and the provider's full, billed charges, as described in the "How Benefits are Paid" Section.

- **Hospitals Outside Arkansas**: If pre-certification is not obtained for a Non-Emergency Hospital Admission outside the state of Arkansas to an In-Network Hospital in a given state, the Plan may deny all or a portion of the charges for such services, depending on whether the particular Hospital and the Host Blue Plan in that state have entered into a provider agreement that specifically makes the In-Network Hospital partly or fully financially responsible for failing to obtain pre-certification. The Plan will deny benefits for such services to the extent that the Host Blue Plan's agreement places financial responsibility for failing to obtain pre-certification on the In-Network Hospital. In such circumstances, you should not be billed for any portion of the financial responsibility that the Host Blue Plan's agreement assigns to the In-Network Hospital. If you utilize an Out-of-Network Hospital outside of Arkansas that fails to obtain pre-certification, the Plan will not deny benefits for such services based solely on the failure of the Out-of-Network Hospital to obtain pre-certification; however, you might also be held responsible by the Out-of-Network Hospital for paying the difference between the Plan Allowance and the provider's full, billed charges, as described in the "How Benefits are Paid" Section.

The Plan excludes and does not cover the first two (2) days of Hospital charges for room and board in connection with weekend, Friday or Saturday, admissions. This exclusion does not apply if the admission is: (i) due to accidental Injury; (ii) for elective surgery on the day of or the day following Hospital admission; (iii) due to an Emergency Illness or Emergency Injury as defined below; or (iv) pregnancy related.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Hospital are parts of the utilization review services program. The Claims Administrator will monitor your Hospital stay or use of other medical services and coordinate with the attending Physician, Hospital and you for the scheduled release, an extension of the Hospital stay, or an extension or cessation of the use of other medical services, as applicable.

If the attending Physician feels that it is Medically Necessary for you to receive additional services or to stay in the Hospital for a greater length of time than has been pre-certified, it is the attending Physician's responsibility to request the additional services or days before the original stay is over. To be covered, each day of your Hospital stay must be Medically Necessary; if the Plan or the Claims Administrator determines that it is no longer Medically Necessary for you to remain in the Hospital, Plan benefits for hospitalization beyond that point will be denied, even if the original hospitalization and an initial number of days were pre-certified.

2. **Pre-certification of Advanced Diagnostic Imaging**

The Plan requires that the Physician first call the Plan's pre-certification service and obtain pre-certification of the Medical Necessity of any Advanced Diagnostic Imaging services, such as an MRI or MRA, a CT scan, a PET scan, Echo Cardiography or Nuclear Cardiology. If pre-certification is not obtained before any Advanced Diagnostic Imaging services are administered to you, the following financial consequences apply, based on whether the services are provided in Arkansas or in another state, and whether you utilize an In-Network or Out-of-Network Provider:

- **In Arkansas**: If Advanced Diagnostic Imaging services are provided in Arkansas by an In-Network Provider but without pre-certification, the Plan will deny all benefits for such services, but the responsibility for the cost of such services will fall on the In-Network Provider who failed to obtain pre-certification, and you should not be billed for any charges for the Advanced Diagnostic Imaging services because the In-Network Provider is obligated not to bill you for such charges. If you utilize an Out-of-Network Provider in Arkansas who fails to obtain pre-certification of Advanced Diagnostic Imaging services, the Plan will not deny benefits for such services based solely on the failure of the Out-of-Network Provider to obtain

pre-certification; however, you might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the provider's full, billed charges, as described in the "How Benefits are Paid" Section.

- **Outside of Arkansas**: If Advanced Diagnostic Imaging services are provided outside the state of Arkansas by an In-Network Provider who fails to obtain pre-certification, the Plan may deny all or a portion of the charges for such services, depending on whether the particular Provider and the Host Blue Plan in that state have entered into a provider agreement that specifically makes the In-Network Provider partly or fully financially responsible for failing to obtain pre-certification. Where pre-certification was not obtained, the Plan will deny benefits for such services to the extent that the Host Blue Plan's agreement places financial responsibility for failing to obtain pre-certification on the In-Network Provider. In such circumstances, you should not be billed for any portion of the financial responsibility that the Host Blue Plan's agreement assigns to the In-Network Provider. If you utilize an Out-of-Network Provider outside of Arkansas who fails to obtain pre-certification of Advanced Diagnostic Imaging services, the Plan will not deny benefits for such services based solely on the failure of the Out-of-Network Provider to obtain pre-certification; however, you might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the provider's full, billed charges, as described in the "How Benefits are Paid" Section.

3. **Pre-certification of Applied Behavioral Analysis (ABA) Therapy**

   The Plan requires that the Physician or member first call the Plan's pre-certification service and obtain pre-certification of ABA therapy services. Failure to obtain per-certification could result in a denial of benefits.

4. **Pre-certification of Medical or Radiation Oncology**

   The Plan requires that the Physician first call the Plan's pre-certification service and obtain pre-certification of the Medical Necessity of any medical or radiation oncology services, such as chemotherapy, brachytherapy, proton beam therapy, and 3D conformal. If pre-certification is not obtained before any medical or radiation oncology services are administered to you, the following financial consequences apply, based on whether the services are provided in Arkansas or in another state, and whether you utilize an In-Network or Out-of-Network Provider:

   - **In Arkansas**: If medical or radiation oncology services are provided in Arkansas by an In-Network Provider but without pre-certification, the Plan will deny all benefits for such services, but the responsibility for the cost of such services will fall on the In-Network Provider who failed to obtain pre-certification, and you should not be billed for any charges for the medical or radiation oncology services because the In-Network Provider is obligated not to bill you for such charges. If you utilize an Out-of-Network Provider in Arkansas who fails to obtain pre-certification of medical or radiation oncology services, the Plan will not deny benefits for such services based solely on the failure of the Out-of-Network Provider to obtain pre-certification; however, you might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the provider's full, billed charges, as described in the "How Benefits are Paid" Section.

   - **Outside of Arkansas**: If medical or radiation oncology services are provided outside the state of Arkansas by an In-Network Provider who fails to obtain pre-certification, the Plan may deny all or a portion of the charges for such services, depending on whether the particular Provider and the Host Blue Plan in that state have entered into a provider agreement that specifically makes the In-Network Provider partly or fully financially responsible for failing to obtain pre-certification. Where pre-certification was not obtained, the Plan will deny benefits for such services to the

extent that the Host Blue Plan's agreement places financial responsibility for failing to obtain pre-certification on the In-Network Provider. In such circumstances, you should not be billed for any portion of the financial responsibility that the Host Blue Plan's agreement assigns to the In-Network Provider. If you utilize an Out-of-Network Provider outside of Arkansas who fails to obtain pre-certification of medical and or radiation oncology services, the Plan will not deny benefits for such services based solely on the failure of the Out-of-Network Provider to obtain pre-certification; however, you might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the provider's full, billed charges, as described in the "How Benefits are Paid" Section.

5. **Emergency Hospital Admissions**

The above requirements do not apply to Hospital admissions as a bed-patient for an Emergency Illness or Emergency Injury*. However, the Claims Administrator must be notified of the emergency Hospital admission within two (2) working days of the covered person being admitted to the Hospital. The Claims Administrator will still review the emergency Hospital admission and treatment to determine if it was both an Emergency Illness or Emergency Injury and Medically Necessary. If it is determined the emergency Hospital admission and treatment was Medically Necessary, the regular Plan benefits will be paid. However, if it is determined the emergency Hospital admission and treatment was not Medically Necessary, charges for Covered Expenses will be excluded under the Plan and no benefits will be paid.

*Emergency Illness or Emergency Injury means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

(i) placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
(ii) serious impairment to bodily functions; or
(iii) serious dysfunction of any bodily organ or part.

If a dispute should arise, the Claims Administrator reserves the right to make the final decision.

6. **Pregnancy**

The Plan 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. This does not guarantee coverage for childbirth.

However, if a Hospital confinement exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean delivery, the Claims Administrator must be notified of the continued Hospital confinement within 24 hours after the initial 48 or 96 hour confinement. If the Claims Administrator is not notified within 24 hours, benefits may be reduced or denied for the continued Hospital confinement. The Claims Administrator will review the continued Hospital confinement and treatment to determine if it is Medically Necessary. If it is determined the continued confinement and treatment are Medically Necessary, the regular Plan benefits will be paid. However, if it is determined the continued Hospital confinement and treatment are not Medically Necessary, no benefits will be paid for those charges.

B. Case Management Services Program

1. Program Administration

The Case Management Services Program is administered by:

BlueAdvantage Administrators of Arkansas
PO Box 1460
Little Rock, AR 72203-1460
(800) 452-6199
Business Hours: 7:00 a.m. – 6:00 p.m. CST Monday-Friday

2. How the Program Works

If a covered person has a serious or extended care Illness or Injury, the Claims Administrator will assign a Case Manager to assist in identifying and coordinating cost-effective medical care alternatives. The Case Management Services Program is a voluntary program designed to:

- Work collaboratively with the healthcare team selected by you to help access your health plan benefits
- Maximize your Plan benefits
- Manage your benefits/needs in the appropriate setting
- Empower you and your family giving you access to greater understanding of your disability or disease through health education
- Enable you and your family to make informed decisions and help you deal with the complexities of the health care system

When appropriate, a specially trained and registered nurse Case Manager working with the Claims Administrator will help you as well as your covered dependents. Circumstances in which a nurse Case Manager will work with you might include any of the following:

- You are sick or injured and hospitalized;
- You are scheduled for surgery;
- You find out you have a chronic illness or are dealing with an ongoing chronic illness;
- You are prescribed multiple prescription drugs with potential interactions;
- You simply have a question about your health;
- You are home from the hospital and need help understanding your discharge plan.

Your nurse Case Manager works for you and with your providers to help you deal with the difficulties associated with Illness or Injury, as well as with routine questions about care and interactions with medical providers. The primary objective of the nurse Case Manager is to identify and coordinate cost-effective medical care while meeting accepted standards of medical practice.

The Claims Administrator may pay for the Alternative Medical Treatment Plan of the patient after an objective review of:
(a) the patient's medical status;
(b) the current course of treatment;
(c) the potential alternative treatment plan(s);
(d) the effectiveness of care; and
(e) the short-term and long-term cost implications;

to determine:

(a) if an Alternative Medical Treatment Plan would be in the best interest of the patient; and
(b) if an Alternative Medical Treatment Plan would be more cost effective.

C. Additional Expert Medical Opinion

You can voluntarily seek additional information about a diagnosis or proposed treatment plan by contacting Advance Medical. Advance Medical is a separate service from the rest of the Plan. Advance Medical doctors will, with your permission, review your medical information from your provider(s) and give you a written report. That report may include additional alternative treatment services that you can discuss with your provider. However, not all treatment services recommended by Advance Medical are covered by the Plan, so you should always verify coverage with the applicable Claims Administrator. Advance Medical can assist with all types of diagnoses or questions, although common examples include cancer diagnosis, possible surgery, complex medical issues, and cases with no diagnosis or conflicting diagnoses. You can access the service at any point during the care process by contacting Advance Medical.

D. Claims Administrator Coverage Polices and Criteria

The Claims Administrator and AIM, the medical and radiation oncology services management administrator, have developed and published on its website specific coverage policies in relation to certain services, treatments, equipment, devices, drugs and supplies. If a coverage policy exists on a service or supply, the coverage policy will determine whether such service or supply meets the primary coverage criteria and any other coverage policy requirements for coverage. If a coverage policy determines that a service, treatment, equipment, device, drug or supply does not meet the primary coverage criteria, or if the service, treatment, equipment, device, drugs or supply does not meet the specific terms of the coverage policy, then this Plan will not provide coverage for that service or supply. The absence of a specific coverage policy with respect to a particular service, treatment, equipment, device, drug or supply does not mean that the service, treatment, equipment, device, drug or supply meets the primary coverage criteria.

E. Definitions

Alternative Medical Treatment Benefits – means benefits for expenses approved before they are incurred, which are:

(1) in connection with an Alternative Medical Treatment Plan; and
(2) may or may not otherwise be payable as a Covered Expense under the Medical Benefits provisions of the Plan.

Alternative Medical Treatment Plan – means a plan for treatment proposed by the Claims Administrator and accepted by the covered person's Physician that is an alternative to a current or proposed course of treatment for an Injury or Illness. Often there is more than one type of service, supply, or accommodation which can be used for the treatment of an Injury or Illness. The Claims Administrator reserves the right to propose other treatment plans, services or providers which, in its sole opinion, are equally effective but less costly than those which are being followed.

If a treatment, service or provider is proposed by the Claims Administrator as an alternative and accepted by your Physician, the proposed plan will be considered a Covered Expense. Services, supplies and accommodations that are used because of the proposed plan which are not covered under this Plan will be paid as an Alternative Medical Treatment Plan. If the covered person rejects the proposed plan, the Claims Administrator reserves the right to pay benefits as though the Alternative Medical Treatment Plan was in effect.

Case Management Services Program – means a professional medical management program for covered persons who are seriously ill, injured or disabled.

Case Manager – means a health care professional who is employed by the Claims Administrator to coordinate individual Case Management Services Programs.

Emergency Hospital Admission – means a Hospital admission due to an Emergency Illness or Emergency Injury.

Non-Emergency Hospital Admission – means a Hospital admission that is not an Emergency Hospital Admission.

SECTION III. HOW BENEFITS ARE PAID

The Medical Benefits portion of the Plan is a Preferred Provider Organization (PPO) Plan. The PPO Plan has a network of providers who have contracted with the Claims Administrator, called In-Network Providers. As a PPO Plan, the benefits for In-Network Providers are greater than those for the services of Out-of-Network Providers. It is important to use In-Network Providers in order to receive the maximum benefit available under the Plan.

This Section describes how the coverage under the Plan works, and how Covered Expenses are paid.

1. **Plan Allowance**

The Plan has defined an outer limit on Plan benefits that applies whether you choose to receive services from an In-Network Provider or an Out-of-Network Provider. This overall limit on the amount of Plan benefits available to you under the Plan is defined in this summary plan description as the "Plan Allowance," and may also be referred to from time to time as the "allowance" under the Plan. Your benefits under the Plan will always be limited by the Plan Allowance that the Plan has adopted, as further defined in this section. ***This means that regardless of how much your health care provider may bill for any service, drug, medical device, equipment or supplies, the benefits under the Plan will be limited to the Plan Allowance, as established in this section.*** The Plan Allowance may be established in the following ways:

(a) **Covered In-Network Services**

For Covered Expenses incurred for services received from an In-Network Provider in Arkansas, the Plan Allowance is the Network Fee Schedule established by the terms of the provider's contract with the Claims Administrator. For Covered Expenses incurred for services received from an In-Network Provider outside the state of Arkansas, the Claims Administrator may not have a direct contract with each provider outside Arkansas; where that is the case, the Plan Allowance for those covered in-network services is determined by the allowance or fee schedule of the provider's contract with the Host Blue Plan.

(b) **Covered Out-of-Network Services**

For Covered Expenses incurred for services received from an Out-of-Network Provider, the Plan Allowance is the amount determined by the Claims Administrator, using the following standards:

(i) for services received in Arkansas, the Plan Allowance for Covered Expenses incurred for services received from Out-of-Network Providers who are physicians and other individual providers, as well as ambulatory surgery centers, home health, hospice, and freestanding dialysis centers or imaging centers, will be the amount of the fee schedule that Arkansas Blue Cross and Blue Shield has contracted with providers in Arkansas for its Preferred Payment Plan network ("PPP"); for hospitals classified as acute care hospitals, the Plan Allowance for covered out-of-network inpatient and outpatient services will be the amount calculated using the Arkansas Blue Cross and Blue Shield Facility Pricing Guidelines.

(ii) for services received outside of Arkansas, the Plan Allowance for Covered Expenses incurred for services received from Out-of-Network Providers will be either the amount provided to Claims Administrator by the Host Blue Plan in that state or, if no such amount is available to Claims Administrator from a Host Blue Plan, then the Plan Allowance will be the amount determined under the formulas for services received in Arkansas, as referenced in (i), above or (iii) below.

(iii) for any services of any provider that are not addressed in any of the existing provider contracts or pricing guidelines referenced above, the Plan Allowance for Covered Expenses incurred for services received from Out-of-Network Providers will be the amount established by Claims Administrator using such pricing methods, benchmarks or sources as Claims Administrator may deem appropriate in the circumstances.

(c) **Your Share of the Plan Allowance and Billed Charges of the Provider**

The Plan calculates and pays Plan benefits on the basis of the Plan Allowance, an amount that may vary substantially from the amount a provider chooses to bill. You should understand that once the Plan Allowance is determined with respect to any provider's billed charges, you may be responsible for a percentage or portion of the Plan Allowance, depending on the terms of the Plan with respect to Copays, Coinsurance, and Deductible. For example, if you use an In-Network Provider, the Plan may pay 80% of the Plan Allowance, in which case you would be responsible for the remaining 20% of the Plan Allowance, but you would not be responsible for the difference between the Plan Allowance and the provider's billed charges. In this situation, the In-Network Provider contract protects you from additional billing beyond the Plan Allowance. For an Out-of-Network Provider, the circumstances are substantially different. For example, if you use an Out-of-Network Provider, the Plan may pay only 50% of the Plan Allowance, in which case you would be responsible for the remaining 50% of the Plan Allowance. However, you might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the provider's full, billed charges.

2. **Maximum Benefits**

The Plan pays a portion of Covered Expenses after any applicable Deductible and/or Copay amount up to the Maximum Benefit amount shown in the Summary of Benefits for each covered person. For specified Covered Expenses, payments are made by the Plan as indicated until the Maximum Benefit has been provided.

3. **Deductible**

The amount of the Individual and Family Deductible is shown in the Summary of Benefits.

The Plan will not begin to pay benefits for Covered Expenses in any calendar year until the Deductible is satisfied (other than for Primary Care Office Visits, telemedicine, urgent care services that are billed as office visits, and Preventive Care Services). The Deductible amount applies separately to each covered person once during each calendar year. The Family Deductible will be satisfied for the calendar year after two (2) or more covered persons have collectively incurred this amount.

The Deductible amounts for In-Network Provider and Out-of-Network Provider Covered Expenses do not apply to one another. If you use In-Network Providers and Out-of-Network Providers, you have to meet equal, but separate deductibles. Out-of-Network Provider Deductible amounts do not apply to the Out-of-Pocket Maximum.

The Deductible **cannot** be met by non-covered expenses or penalties.

4. **Copays**

Hospital emergency department visits are subject to Deductible, Copay, and Coinsurance as shown in the Summary of Benefits. The Copay is waived when the patient is admitted to the Hospital.

Primary Care Office Visits, telemedicine, and urgent care services that are billed as office visits (other than Preventive Care Services) are subject to a Copay. These services are not subject to the Deductible.

5. **Coinsurance Percentage Paid Under The Plan**

Once any applicable Deductible and/or Copay amount is satisfied, the Plan pays a percentage of Covered Expenses, up to any specified Maximum Benefit amount. The percentage the Plan pays varies, depending on the type of service and whether the service was obtained by In-Network or Out-of-Network Providers as shown in the Summary of Benefits. When the Plan payment is less than 100%, the remaining percentage is your Coinsurance.

All 20% Coinsurance payments under the Medical Plan, Copays and Deductibles for In-Network Provider services are applied toward the In-Network Out-of-Pocket Maximum. When the Out-of-Pocket Maximum has been met, the Plan begins to pay 100% for Covered Expenses (up to the Plan Allowance for each Covered Expense) for the remainder of that calendar year.

6. **Out-of-Pocket Maximum**

The Out-of-Pocket Maximum amount as shown in the Summary of Benefits applies separately to each covered person once during each calendar year. The Family Out-of-Pocket Maximum will be satisfied for the calendar year after two (2) or more covered persons have collectively incurred this amount; however, no individual covered person will be required to exceed the Individual Out-of-Pocket Maximum for a calendar year.

The Medical Benefits Out-of-Pocket Maximum can be met by payments of Coinsurance, Copay and Deductible amounts for Covered Services obtained through In-Network Providers or In-Network Transplant Centers. When the Out-of-Pocket Maximum has been met, the Plan begins to pay 100% for Covered Expenses (up to the Plan Allowance for each Covered Expense) for the remainder of that calendar year, not to exceed the Maximum Benefit.

The Medical Benefits Out-of-Pocket Maximum **cannot** be met by non-covered expenses, penalties, Coinsurance, Copay or Deductible amounts for services obtained from Out-of-Network Providers. The Out-of-Pocket Maximum for Medical Benefits is separate from the Out-of-Pocket Maximum for Prescription Drug Benefits. This means Prescription Drug expenses do not count toward the Out-of-Pocket Maximum for Medical Benefits.

7. **Network Providers/Provider Reimbursement**

This Plan gives you a choice of who provides your medical care. Your medical care may be provided by an In-Network Provider or any other health care provider.

An In-Network Provider is a Hospital, Convalescent/Skilled Nursing Facility, Physician, or other qualified provider of medical services or supplies who has a predetermined contractual agreement with either the Claims Administrator or the Host Blue Plan (outside the state of Arkansas) to provide Medically Necessary care and treatment at set rates known as the Network Fee Schedule. Covered Expenses for services of In-Network Providers are paid based on the Plan Allowance for in-network services, which is the contracted Network Fee Schedule. In addition, In-Network Providers agree to accept the Network Fee Schedule amount (consisting of the Plan's portion plus your portion) as payment in full.

Any provider who does not have a contractual agreement with either the Claims Administrator or a Host Blue Plan to provide Medically Necessary care and treatment at set rates is an Out-of-Network Provider. Covered Expenses for services of Out-of-Network Providers are paid based on the Plan

Allowance for out-of-network services as established by the standards described in paragraph 1, above ("Plan Allowance"). Out-of-Network Providers can bill you for any difference between their billed charge and the Plan Allowance.

The Deductible amount and Covered Expenses payment rates may vary between the In-Network Provider and the Out-of-Network Provider, where In-Network Providers are available. The Plan includes benefit incentives to go to an In-Network Provider, but you are not required to do so.

8. **Notice of Provider Incentives – How Payment Programs for Network Providers May Affect Your Health Care**

The Plan has elected to participate in new health care provider payment initiatives that offer financial incentives – both potential rewards and possible penalties – to providers based on their ability to meet or exceed certain quality and cost targets or standards.

For example, a Physician may be offered an incentive program in which the Physician's performance of a particular kind of health care service, such as a hip or knee replacement surgery, is evaluated in terms of the average cost of the surgery when performed by the Physician, as well as whether or how often the Physician meets certain defined quality standards when performing such surgery. Under such an incentive program, the Physician may be told that the incentive program target for average Physician cost is, for example, $5,000. The Physician also may be informed of five or six quality indicators that the incentive program will require be confirmed in all or a high percentage of the Physician's hip/knee surgical cases, in order to qualify for incentive payments.

Under such an incentive program, if the average cost for all hip and knee replacement surgeries performed by the Physician during a defined review period (for example, 12 months) exceeds the program target average cost of $5,000, the Physician would be responsible for refunding a portion of such excess costs to insurers or self-funded health benefit plans (such as the Plan). Such refunds for excess average costs might be recovered from the Physician through what are known as "withholds," whereby the insurer or self-funded health benefit plan would withhold a certain percentage from future claims payments otherwise due to the Physician, until the excess cost amount is fully recovered. On the other hand, if the average costs for all hip and knee replacement surgeries performed by the Physician during a defined review period was less than the program target average cost of $5,000, the Physician would qualify to receive additional incentive payments (sometimes called "bonus" payments) from the insurer or self-funded health benefit plan (including your Plan) as a reward for reducing the Physician's average cost for such surgeries.

The preceding is simply one example of a possible incentive program; there are very likely to be numerous other types of incentive programs focusing on different kinds of surgeries, medical treatments, or "episodes of care." While the precise working or content of each incentive program may vary, the goal of all such incentive programs is the same: to give the provider financial incentives to control costs of services, as well as financial incentives to maintain certain quality standards. "Episode of Care" is a term that refers to the grouping of certain sets of medical services that may be provided over an extended period of time into one "episode" for purposes of quality and cost evaluation. Hip and knee replacement surgeries are one such type of "episode of care," but there are likely to be many others, which could focus on virtually any aspect of health care services, procedures, surgeries or treatments. Please note as well that although the example above refers to Physician services and charges, the provider incentive programs in which the Plan has elected to participate may include other categories of providers, not just Physicians. Also, you should be aware that any Deductibles and Coinsurance, or other Plan participant cost-sharing provisions of the Plan shall not apply in any manner to any incentive payments or withholds that result from participation in the incentive programs.

Should you have any concerns about whether your provider is participating in a provider incentive program, or how the potential for reward or penalty in that program might affect the provider's provision of health care services to you, you should ask your treating provider or their administrative staff about such incentive program participation prior to receiving any health care services. Additional details on incentive programs in which the Plan participates as of a certain date can be obtained by writing to the Claims Administrator. Please note that the types of provider incentive programs, or the specifics of such programs, including payment methods or methods of calculating potential rewards or penalties, may change from time to time, and could be changed quickly, as conditions in the health care or financing marketplace change. Accordingly, you may want to request updated information from your treating provider, or request it from the Plan, prior to undergoing a specific course of treatment.

9. **Information About the BlueCard Program Utilized by BlueAdvantage Administrators of Arkansas**

As the Claims Administrator, BlueAdvantage participates in a national program called the BlueCard Program. This program ensures that members of any Blue Cross and/or Blue Shield Plan have access to the advantages of participating BlueCard PPO providers throughout the United States.

The BlueCard Program provides conveniences and benefits outside the Arkansas service area in which BlueAdvantage operates. **A provider outside of Arkansas is considered to be an In-Network Provider only if they are BlueCard PPO providers**. Therefore, whenever possible, before receiving services outside of Arkansas, you should ask the provider if he or she participates with the Blue Cross and Blue Shield PPO Plan in that state. To locate BlueCard PPO providers in any state, call 800-810-BLUE.

When a covered person receives services from a BlueCard PPO provider, the Plan will provide benefits at the same level as for In-Network Providers. BlueCard PPO providers file claims for you, and payments will be made directly to the BlueCard PPO provider.

The amount you pay for Covered Expenses is usually calculated on the lower of:

* The actual billed charges for your Covered Expenses, or
* The negotiated price that the local Blue Cross or Blue Shield Plan passes on to BlueAdvantage

Often, this negotiated price consists of a simple discount that reflects the actual price paid by the local Blue Plan. Sometimes, it is an estimated price that factors in expected settlements, withholds, and other contingent payment arrangements and non-claims transactions with the provider or a specific group of providers.

The negotiated price may also be billed charges reduced to reflect an average expected savings with the provider or group of providers. A price that reflects average savings may result in greater variation from the actual price paid than will an estimated price. The negotiated price may also be prospectively adjusted to correct for over- or under-estimates of past prices; however, the amount you pay is considered a final price.

Statutes in a few states may require the local Blue Plan to use a basis for calculating your payment obligation for Covered Expenses that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. In such a case, your payment obligation would be calculated in accordance with the applicable state statute in effect at the time the covered person received care.

SECTION IV. COVERED MEDICAL BENEFITS

A. Covered Expenses

Except for any covered preventive care, services and supplies must be Medically Necessary for the treatment of an Illness or Injury and, whether or not for covered preventive care, must not be considered Experimental and/or Investigational in order to be considered a Covered Expense. Expenses must also meet any applicable coverage criteria of the Claims Administrator. Refer to the Definitions in this Section IV for these descriptions. Benefits are subject to the Deductible, Copay, and Coinsurance and will be paid for Covered Expenses as shown in the Summary of Medical Benefits. Benefits will not exceed the maximums shown. Covered Medical Benefits are also subject to the Utilization Review and Case Management Program provisions in Section II.

1. **Hospital Services**. Hospital room, board and general nursing care, intensive care while confined in an Intensive Care Accommodation, and charges for other Hospital services and supplies necessary for treatment of Injury or Illness, except services furnished by outside agencies and supplies not used while confined in the Hospital. Other Hospital services received on an outpatient basis for a surgical operation, pre-admission testing or for treatment of bodily injuries in the outpatient department of a Hospital.

2. **Convalescent Facility/Skilled Nursing Facility Care**. Convalescent or Skilled Nursing Facility room, board and general nursing care which immediately follows confinement in a Hospital.

3. **Organ and/or Tissue Transplant Benefit**. Charges made for or in connection with pre-approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs if the recipient is covered under the Plan. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan.

   The transplants covered under this benefit and require pre-certification are:

   Heart;
   Pancreas;
   Liver;
   Pancreas/Kidney;
   Heart/Lung;
   Lung or double lung;
   Isolated small bowel
   Small bowel
   Liver, and other viscera
   Islet cell
   Bone marrow/hematopoietic stem cell

   Other transplants covered under this benefit, but do not require pre-certification are:

   Kidney;
   Cornea

   If you or your Dependent are in need of the above-listed transplants (whether or not requiring pre-certification), you should contact the Claims Administrator to discuss the benefits available under this provision. The Plan gives you a choice of who provides your care; however, to receive the maximum benefits you will need to use In-Network Transplant Centers. (In-Network Transplant Centers may differ from In-Network Providers. Refer to Definitions at the end of this Section). These Transplant Centers offer programs recognized for providing quality care for organ and/or tissue transplants. These programs are often able to minimize complications, control the amount

of time spent in the Hospital and reduce the chances of repeat transplants. Generally, these facilities have agreed to provide services for listed organ and/or tissue transplants to covered patients for the Plan Allowance, which may be a global payment. The Plan will not pay any amounts in excess of the Plan Allowance for services the Hospital, Physicians, or other suppliers may bill separately, because the Plan Allowance includes payment for all related services (other than non-covered services). If you use In-Network Transplant Centers, they have agreed to accept the Plan Allowance as payment in full, and should not bill you for any amount above the Plan Allowance, except for applicable Deductible, Coinsurance, or non-covered services. If you receive a transplant from a Hospital that is an In-Network Provider, but is not an In-Network Transplant Center, the Plan will only reimburse the In-Network Provider based on the Plan Allowance amount for an In-Network Provider, and may result in a higher out-of-pocket for you.

Not all transplants are covered. There may be a specific coverage policy recognized by the Claims Administrator which allows benefits for the transplant in question, and you must meet all of the required criteria necessary for coverage set forth in the coverage policy.

Transplant Travel Benefit. The Claims Administrator will pay, subject to the Transplant Travel Benefit Maximum shown in the Summary of Medical Benefits, travel expenses incurred by a covered person for charges for transportation, lodging and food associated with a covered organ transplant. All expenses must be pre-approved by the covered person's transplant Case Manager. Benefits for transportation, lodging and food are available only if you or your covered Dependent is a recipient of a covered organ/tissue transplant from an In-Network Transplant Center. However, if the requested transplant is not offered by an In-Network Transplant Center, then benefits for transportation, lodging and food may be available if you or your covered Dependent is the recipient of a covered organ/tissue transplant from an In-Network Provider for the requested transplant. The term recipient is defined to include a covered person receiving covered transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care.

If you or your Dependent elects to use an In-Network Transplant Center (or an In-Network Provider, if an In-Network Transplant Center does not offer the requested transplant as described above), and treatment at such facility has been pre-approved by the Claims Administrator, travel expenses for the person receiving the transplant will include charges for:

(1) transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant center);
(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 will not include any charges for:

(a) transportation, lodging and food associated with an organ transplant performed at any center other than an In-Network Transplant Center (or an In-Network Provider, if an In-Network Transplant Center does not offer the requested transplant as described above);
(b) transplant travel benefit costs incurred due to travel within 60 miles of your home;
(c) air travel via air ambulance;
(d) laundry bills;
(e) telephone bills;
(f) alcohol or tobacco products; or
(g) transportation charges which exceed coach class rates.

The charges associated with the items (1), (2) and (3) will be considered travel expenses for only one companion at any time in addition to the actual transplant recipient. The term companion

includes a spouse, family member, legal guardian of you or your Dependent, or any person not related to you, but actively involved as your caregiver.

Transplant Travel Benefits may be considered to be taxable income by the Internal Revenue Service. Please consult with your own tax advisor for further information.

4. **Home Health Care**. The Plan covers services provided by a licensed Home Health Care Agency for care in the home for medical reasons, when a covered person is physically unable to obtain necessary medical care on an outpatient basis and is under the care of a Physician as follows:

   - part-time or intermittent nursing care by or under the supervision of a registered professional nurse or licensed practical nurse if the services of a registered nurse are not available;
   - physical therapy, occupational therapy, and speech therapy provided by the Home Health Care Agency, subject to the limitations shown in the Summary of Medical Benefits; and
   - medical supplies, drugs and medicines prescribed by a Physician and laboratory services by or on behalf of a Hospital, to the extent that such items would have been covered under this Plan if the covered person had been confined in the Hospital; however, this does not include prescribed drugs that can be self-administered or specialty medications that must be obtained through the Specialty Pharmacy Services benefit.

5. **Phenylketonuria (PKU)**. Amino acid elemental formula is payable with an associated diagnosis of PKU and for a period no longer than 3 months unless there is case management approval.

6. **Hospice Care**. Charges made by a Hospice Care Team when a Physician certifies that the covered person is a Terminally Ill Person for the following expenses:
   - room and board and general nursing care in a free standing hospice;
   - Emotional Support Services provided in the counseling session with the covered person or the family to assist in coping with the death of a Terminally Ill Person, including bereavement counseling; and
   - homemaker services.

7. **Professional Services**. Charges for the following expenses:

   - Physicians' fees for medical care and surgical operations including a second surgical opinion in connection with a surgical operation or procedure.
   - Charges by anesthetists not employed by Hospitals for administration of anesthetics in connection with surgical operations.
   - Physicians' fees for assisting at surgery when Medically Necessary. The Claims Administrator reserves the right to determine if the assistant surgeon's services are Medically Necessary.
   - Charges of a registered graduate nurse, or a practical nurse who is either licensed as a practical nurse or is registered with an organization having the approval of the medical profession for medical care of Injury or Illness.
   - Office-based vergence/accommodative therapy for patients with symptomatic convergence insufficiency subject to the Claims Administrator's coverage policy.

8. **Newborn Charges**. Charges for usual nursery and Hospital pediatric care of a newborn child will be covered under the child's expense, if the newborn is a covered Dependent.

9. **Psychiatric Day Facility**. Benefits will be paid for treatment in a Psychiatric Day Facility, as defined in this Section IV, if the attending Physician certifies treatment of a mental or emotional Illness or disorder and indicates the treatment is in lieu of Hospitalization.

10. **Rehabilitation Services**. Benefits will be paid for speech therapy, physical therapy, and/or occupational therapy. Outpatient therapy, long term acute care and acute inpatient rehabilitation services are subject to the limitations shown in the Summary of Medical Benefits.

11. **Chiropractic Care/Spinal Manipulation**. Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column, and is subject to the limitations shown in the Summary of Medical Benefits.

12. **Emergency Department**. Services in a Hospital emergency department for treatment of an Illness or Injury.

13. **Out-of-Network Emergency Services**. In an Emergency, you should go immediately to the nearest Hospital. Examples of Emergencies include, but are not limited to the following: unusual or excessive bleeding; open fractures; acute abdominal or chest pains; suspected heart attacks; sudden, persistent pain; serious injuries or burns; poisonings; unconsciousness; convulsions; or difficulty in breathing. A condition that would normally be treated in a Physician's office is not considered an Emergency.

    Emergency services rendered by Out-of-Network Providers may be eligible for additional reimbursement (not to exceed 80% of the Plan Allowance amount or any equivalent standard applied by the Claims Administrator) only when the condition treated was an Emergency. Refer to the Claims Review Process in Section X for details regarding how to submit additional information for determination of additional reimbursement. Additional information may include written proof of the occurrence, character and extent of Emergency services. Final determination of covered conditions will be made by the Claims Administrator.

14. **Covered Expenses When an In-Network Provider Is Not Available**. Services rendered by an Out-of-Network Provider may be eligible for additional reimbursement (not to exceed 80% of the Plan Allowance amount or any equivalent standard applied by the Claims Administrator) if the type of care you need is not available from an In-Network Provider.

    If you transfer from one facility to an Out-of-Network Provider facility, charges for the second facility will be paid at the Out-of-Network Provider Plan Allowance, unless services were not available from an In-Network Provider facility.

    Refer to the Claims Review Process in Section X for details regarding how to submit additional information for determination of additional reimbursement. Additional information may include written proof of the occurrence, character and extent of services. Final determination of covered conditions will be made by the Claims Administrator.

15. **Preventive Care Services**. Regardless of Medical Necessity, the Plan covers preventive care services such as:

    - Wellness exam
    - Routine mammogram and pap smear
    - Well child exams
    - Routine immunizations
    - Routine hearing exam
    - Contraceptives and administration, other than those that are self-administered or covered under the Prescription Drug Benefits

The Plan will comply with the Affordable Care Act. A complete listing of Affordable Care Act Preventive Care Services can be accessed at https://www.healthcare.gov/coverage/preventive-care-benefits/, although the Plan will only cover the applicable Preventive Care Service to the extent required under the Affordable Care Act. Such services are subject to medical management and other permitted limitations on frequency or scope that the Plan Administrator may impose as described in the other sections of this document.

The professional exam is also covered based on the applicable Primary Care Office Visit or Specialty Office Visit charge and whether diagnostic or preventive in nature. Preventive Care Services do not include items that are Experimental and/or Investigational Services.

16. **Durable Medical Equipment and Supplies, Prosthetic and Orthotic Devices**. Charges for the following items when certified as Medically Necessary by the Claims Administrator: artificial limbs or eyes, casts, splints, trusses, braces, crutches, prostheses following a mastectomy; rental of apnea monitors, wheel chair, Hospital-type bed, iron lung or other durable equipment (not to exceed the purchase price) manufactured exclusively for treatment of Injury or Illness; oxygen and rental of equipment (not to exceed the purchase price) for administration of oxygen; the first pair of eyeglasses or contact lenses prescribed due to a cataract operation or glaucoma, unless a lens implant was performed; custom-made orthotics; and diabetic shoes (limited to two per calendar year).

    Rental of durable medical equipment required for temporary therapeutic use. This does not include air conditioners, air purifiers, humidifiers, dehumidifiers or comfort items. When it is more cost effective, the Plan may allow purchase rather than rental of covered equipment.

17. **Mental/Nervous and Substance Abuse Treatment**. Psychiatric treatment or consultation during confinement as a bed-patient in a Hospital, charges for convulsive therapy and treatment in a Psychiatric Day Facility, charges for outpatient psychiatric care, testing, and treatment and substance abuse treatment subject to the following:

    (1) **Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions**. Coverage for Mental/Nervous and Substance Abuse Treatment inpatient hospitalization, partial hospitalization programs or intensive outpatient programs is subject to the following requirements:
        (a) Inpatient hospitalization requires a patient to receive services that are Covered Expenses 24 hours a day as an inpatient in a Hospital.
        (b) Multidisciplinary treatment through partial hospitalization that occurs a minimum of six hours per day for a minimum of five days per week in a Hospital outpatient setting.
        (c) Multidisciplinary treatment through intensive outpatient that occurs a minimum of three hours per day for a minimum or three days per week in a Hospital outpatient setting.

    (2) **Non-Hospital Health Interventions**.

        (a) Coverage is provided for services and supplies provided during an office visit with a Physician licensed to provide treatment for Mental Illness or Substance Use Disorders.
        (b) Applied Behavioral Analysis therapy will be covered for children diagnosed with autism, pursuant to accepted diagnostic criteria recognized by the Claims Administrator.
        (c) Coverage for Mental Illness or Substance Use Disorder services and supplies at a Residential Treatment facility is subject to the following requirements:
            (i) The facility is licensed by the appropriate agency in the state where the facility is located.
            (ii) The facility is accredited by the Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).

(iii) A request for Pre-certification must be submitted to the Claims Administrator prior to admission to the Residential Treatment facility.
(iv) Coverage is provided subject to the limit shown in the Summary of Medical Benefits.
(v) The services must be of a temporary nature and required to increase ability to function.

18. **Tobacco Cessation Program**. Coaching, support and assistance are provided to help covered persons age 18 and over stop tobacco use. This program is administered by Optum. The program places emphasis on personalized education and the development of a quit plan. Five telephone coaching sessions are conducted over a span of six to eight weeks. A maximum eight week supply of approved nicotine replacement therapy is available through Optum at no charge once per calendar year to covered persons who pass a medical screening or provide an executed Physician Authorization form. After this initial supply is exhausted, a covered person can obtain two additional twelve week cycles per calendar year of nicotine replacement therapy through the Prescription Drug Benefits under the Plan at no charge, provided that he or she first obtains a prescription from his or her Physician. Applicable cost sharing requirements must be satisfied for additional supplies. An "approved nicotine replacement therapy" is either a nicotine replacement patch or nicotine chewing gum that has been approved by the Plan Administrator for covered persons enrolled in the Tobacco Cessation Program and is supplied by Optum or obtained through the Prescription Drug Benefits under the Plan, as applicable. Covered persons enrolled in the Tobacco Cessation Program also have access to Prescription Drug Benefits for the treatment of tobacco addiction. Participation in the telephone counseling portion of the program is unlimited.

19. **Cochlear Implants**. Implantable hearing devices subject to the Claims Administrator's coverage policy. A Food and Drug Administration (FDA)-approved cochlear implant is covered when the device is implanted for FDA approved indications and is certified as Medically Necessary by the Claims Administrator.

20. **Gender Dysphoria.** Gender reassignment surgery is covered for covered persons age 18 and older, including both male to female surgery and female to male surgery. To be eligible for gender reassignment surgery, the covered person must have been diagnosed with gender dysphoria by a Physician pursuant to accepted diagnostic criteria recognized by the Claims Administrator and the Claims Administrator's coverage policy conditions must be satisfied. The Plan will also cover related hormone replacement therapies, including laboratory testing to monitor home therapy, and psychotherapy visits.

21. **Primary Care Physician Office Visits**. Coverage is provided for the diagnosis and treatment of Illness or Injury when provided in the medical office of your Primary Care Physician (PCP). You are expected to select and maintain a patient-physician relationship with a PCP. A PCP can be helpful to you in a managing your health care. The PCP selected must be an In-Network Provider listed in the Claims Administrator's Preferred Provider Directory as a PCP and must be accepting covered persons. You may contact the Claims Administrator's Customer Service Department to select or change your PCP.

22. **Telephone or Electronic Consultation ("Telemedicine")**. Charges for consultations with a Physician via telephone or over the internet, but only if provided by an approved telemedicine provider designated by the Plan Administrator.

23. **Genetic Testing**. Genetic testing is covered to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic covered person's blood or tissue to determine if the covered person has a specific disease or condition, and (6) genetic

testing to determine the anticipated response to a particular pharmaceutical, are not covered. However, subject to the terms, conditions, exclusions and limitations of the Plan, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Claims Administrator has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the covered person's treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. The Claims Administrator has full discretion in determining which particular genetic tests may be eligible for benefits as an exception to this exclusion. There may be a specific coverage policy regarding genetic testing that will control whether or not benefits are available for that genetic test as an exception to this exclusion.

24. **Diabetic services**. Treatment services including but not limited to an eye examination to screen for diabetic retinopathy for covered persons who are diagnosed with diabetes, foot care when required for prevention of complications associated with diabetes mellitus, diabetic screening as recommended under Preventive Care Services, and diabetic self-management training and education when prescribed by the attending Physician. Services must be provided by an accredited or certified program.

25. **Fertility Services**. Charges for pre-treatment counseling and one (1) Smart Cycle Fertility Treatment per employee or covered spouse per lifetime when pre-authorized and obtained through an In-Network Progyny Fertility Provider as follows:

    - Two (2) consultations per year at a credentialed In-Network Progyny Fertility Provider. Consultations are an opportunity to discuss and explore the possible reasons why one may be struggling to conceive. Consultations outline potential diagnostic testing protocols and possible treatment options.
    - Diagnostic testing - performed to assess reproductive organ functionality to determine the root cause of an inability to conceive. Fertility specialists can make a treatment recommendation following the assessment of the diagnostic testing results.
    - Transvaginal Ultrasound - a type of pelvic ultrasound used by doctors to visually examine female reproductive organs. This includes the uterus, fallopian tubes, ovaries, cervix, and vagina.
    - Pre-implantation Genetic Screening (PGS) - a procedure performed to ensure embryo viability. PGS ensures that the embryo chosen for transfer has the correct number of chromosomes.
    - In Vitro Fertilization (IVF) - includes cycle management via in-cycle monitoring, office visits, blood work, ultrasounds, oocyte retrieval and identification, fertilization, embryo assessment via PGS testing followed by the embryo transfer.
    - Intrauterine Insemination (IUI) - a procedure in which semen is placed into the uterus directly using a catheter.
    - Intracytoplasmic Sperm Injection (ICSI) - a procedure performed to increase fertilization.
    - Embryo assessment and transfer - analyzes early embryo development and aids in the selection and transfer of the best embryo.
    - Fertility preservation with up to one (1) year of storage (egg, embryo, ovarian tissue or sperm) only when pending medical treatment for cancer.

26. **Other Services**. Charges for the services named below when certified as Medically Necessary by the Claims Administrator:

    - Anesthetics and their administration, including dental anesthesia when performed in an outpatient facility or Physician's office.

- Drugs and medicines which have been approved for use by the Food and Drug Administration when administered to you as an inpatient or as an outpatient of a Hospital, Convalescent/ Skilled Nursing Facility, or Residential Treatment facility.
- Injectable medications, intravenous injections and solutions when administered to you by a Physician or practitioner other than prescribed drugs that can be self-administered or specialty medications that must be obtained through the Specialty Pharmacy Services benefit.
- Diagnostic laboratory services.
- Blood and blood derivatives that are not donated or replaced.
- Services of a physiotherapist or laboratory technician.
- Use of x-ray, radiation or chemotherapy and treatment with radioactive substances.
- Local professional ambulance service to the nearest Hospital or Convalescent/Skilled Nursing Facility where care and treatment of the Injury or Illness can be given.
- Ambulance services rendered if Medically Necessary, even when transport is not required.
- Sleep studies performed by a Physician at a licensed sleep center or Hospital and portable (at home) sleep studies when all of the following seven channel monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used for portable (at home) sleep studies are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.
- The Plan Sponsor may institute pilot programs to evaluate alternative benefit programs for covered persons during a calendar year. These pilot programs may be discontinued at any time at the sole discretion of the Plan Sponsor.
- Treatment of Acquired Immunodeficiency Syndrome (AIDS).
- Allergy-related services, including testing, extracts and injections.
- Cardiac rehabilitation services when ordered by a Physician.
- Items or services that are otherwise Covered Expenses under the Plan that are associated with participation in Phases I-IV of approved clinical trials to treat cancer or other life-threatening conditions, as determined by the Claims Administrator and as required by law, not to include the cost of the item or service that is the subject of the clinical trial, any Experimental or Investigational items, devices or services, items that are provided for data collection or services that are inconsistent with widely accepted and established standards of care for a particular diagnosis.

Covered Expenses shall not include any charges for which benefits are payable under any other provisions of the Plan.

A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained.

B. Proof of Claim

The Claims Administrator reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for Covered Expenses. As part of the basis for determining benefits payable, the Claims Administrator may require submission of operative reports and other appropriate diagnostic and evaluative materials. When these materials are unavailable, and to the extent that verification of Covered Expenses cannot reasonably be made by the Claims Administrator based on the information available, benefits for the course of treatment may be denied or reimbursed at a lesser amount than that which otherwise would have been payable.

C. Definitions

Convalescent/Skilled Nursing Facility – means a lawfully operating institution, or a distinct part of an institution, primarily engaged in providing skilled nursing care and “Physical Restoration Services”

to patients recovering from Injury or Illness and which: is under the resident supervision of a Physician or a registered graduate nurse; requires that the health care of every patient be under the supervision of a Physician and provides that a Physician be available to furnish necessary medical care in emergencies; provides for nursing service continuously for twenty-four hours of every day; provides facilities for the full-time care of five or more patients; and maintains clinical records on all patients. As used in this provision, "Physical Restoration Services" means services which assist the patient to achieve a degree of body functioning sufficient to permit self-care in the essential activities of daily living.

Covered Expenses – means charges for services, supplies, and accommodations which are certified by the Claims Administrator to be Medically Necessary for treatment or are for Preventive Care Services and are listed as eligible for coverage under Section IV.A. Benefit payments for Covered Expenses are subject to the other provisions of the Plan.

Custodial Care – means care rendered to a covered person (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in a home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A Custodial Care determination is not precluded by the fact that a covered person is under the care of a supervising or attending Physician and that services are being ordered or prescribed to support and generally maintain the covered person's condition, or provide for the covered person's comfort, or ensure the manageability of the covered person. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by an RN, LPN, or LVN or the ordered and prescribed services and supplies are being performed in a Hospital, nursing home, Skilled Nursing Facility, extended care facility or in the home. The determination of Custodial Care in no way implies that the care being rendered is not required by the covered person; it only means that it is a type of care that is not covered under the Plan.

Emotional Support Services – means a program for meeting the special physical, psychological, spiritual and social needs of a person.

Experimental or Investigational. The Claims Administrator shall have full discretion to determine whether a drug, device or medical treatment is Experimental or Investigational. Any drug, device or medical treatment may be deemed Experimental or Investigational, in the Claims Administrator's discretion, if:

(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or
(b) the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review and approval;
(c) Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;
(d) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum

tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

(e) Reliable Evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure neither supports nor denies its use for a particular condition or disease.

(f) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

(1) the patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;
(2) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;
(3) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
(4) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the injury, illness or condition at issue; or
(5) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

Home Health Care Agency – means a:

(a) Hospital possessing a valid operating certificate issued in accordance with the state public health law authorizing the Hospital to provide Home Health Care Services;
(b) public home health care service or agency possessing a valid certificate of approval issued in accordance with such state public health law; or
(c) Home Health Care Agency which is federally certified.

Home Health Care Plan – means a program for care and treatment established and approved in writing, including an estimation of the duration of such program by the attending Physician, together with such Physician's certification that the proper treatment of the Injury or Illness would require confinement as a bed-patient in a Hospital in the absence of the services and supplies provided as a part of the Home Health Care Plan.

Hospice Care Plan – means a plan, in writing, by the attending Physician for home or inpatient hospice care which treats the special needs of the Terminally Ill Person and his or her family. The Hospice Care Plan must be approved by the Claims Administrator as meeting established standards, including any legal licensing requirements of the state or locality in which it operates.

Hospice Care Team – means a group of trained medical personnel and counselors.

Hospital – means an institution legally operating as a Hospital which is (1) primarily engaged in providing, for compensation from its patients, inpatient medical facilities for diagnosis and treatment of Injury or Illness, and (2) operated under the supervision of a staff of Physicians and continuously provides nursing services by registered graduate nurses for twenty-four hours of every day. In no event, however, shall such term include any institution which is operated principally as a rest, nursing or convalescent home, or any institution or part thereof which is principally devoted to the care of the aged, or any institution engaged in the schooling of its patients.

Host Blue Plan – means the Blue Cross and Blue Shield plan in the state where services are provided (other than Arkansas).

Illness – means sickness or disease, mental infirmity, substance abuse, and pregnancy, which requires treatment by a Physician.

In-Network Progyny Fertility Provider – means a health care provider that provides approved fertility treatment services and which has entered into a network participation contract with Progyny, Inc.

In-Network Provider – means a health care provider who has entered into a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with a Host Blue Plan.

In-Network Transplant Center – means a health care facility that provides organ and/or tissue transplants and which has entered into a network participation contract with either the Claims Administrator, or outside the state of Arkansas, with a Host Blue Plan, or with the national Blue Cross and Blue Shield Association and that, in any case, is also designated as a "Blue Destination Center for Transplants."

Injury – means bodily injury, which requires treatment by a Physician.

Intensive Care Accommodation – means an accommodation which is reserved for critically and seriously ill patients requiring constant audio-visual observation as prescribed by the attending Physician, and which provides room and board, nursing care by nurses whose duties are confined to care of patients in the intensive care accommodation, and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

Medically Necessary/Medical Necessity – means care and treatment recommended or approved by a Physician, and is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

Mental Illness – means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. This includes, but is not limited to schizophrenic spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, elimination disorders, sleep-wake disorders, sexual dysfunctions, gender dysphoria, substance-related and addictive disorders, neurocognitive disorders, paraphilic disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

Network Fee Schedule – means, with respect to benefits other than vision and dental benefits the allowance, fee schedule or payment amount established under the terms of an In-Network Provider's network participation contract. The contract may be with the Claims Administrator or with a Host Blue Plan.

Neurological Rehabilitation Facility – means an institution licensed as such by the appropriate state agency and must:

(a) be operated pursuant to law;

(b) be accredited by the Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities;
(c) be primarily engaged in providing, in addition to room and board accommodations, rehabilitation services for severe traumatic brain injury under the supervision of a duly licensed Physician (M.D. or D.O.); and
(d) maintain a daily progress record for each patient.

Out-of-Network Provider – means a health care provider who does not have a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with a Host Blue Plan.

Physician – means those physicians legally licensed to practice medicine and surgery and any other legally licensed practitioner of the healing arts who render services within the scope of his or her license.

A. For purposes of the Plan, the list of practitioners shall include:

Physician (Medical Doctor)	Pharmacist
Osteopath	Dentist
Licensed Psychologist (PhD)	Podiatrist
Optician	Chiropractor
Optometrist	Counselors
Speech Pathologist	Social Worker
Advanced Nurse Practitioner	Physician Assistant

B. The services of the following practitioners may be covered if determined to be Medically Necessary:

Physician Therapist	Audiologist
Respiratory Care Practitioner	Occupational Therapist
Licensed Vocational Nurse (LVN)	Licensed Practical Nurse (LPN)
Registered Nurse (RN)	Medical Health Nurse
Nurse Specialist	Dental Hygienist
Advanced Clinical Practitioner	Dietician
Nutritionist	

C. Midwives are considered as an eligible practitioner provided they are a Registered Nurse and licensed by the state.

D. The following practitioners are not considered eligible under the Plan:

Denturist	Naturopath
Practitioners of Oriental Medicine	

For purposes of this Plan, the Claims Administrator reserves the right to make the final decision as to whether any practitioner not named above is covered under the Plan.

Plan Allowance – means the maximum amount the Plan will cover or pay for any Covered Expense. The Plan Allowance includes the Plan's share of Covered Expenses as defined by the Plan, as well as your share of Covered Expenses as defined by the Plan, including Deductibles, Copays, Coinsurance, or any other cost-sharing.

Psychiatric Day Facility – means a facility that meets the following criteria:

(1) treat a patient for not more than 8 hours in any 24-hour period;
(2) be clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology; and

(3) be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Residential Treatment – means treatment for patients that require close monitoring of their behavioral and clinical activities related to their psychiatric treatment or to their chemical dependency or addiction to drugs or alcohol. Residential treatment services must be approved by the Claims Administrator as meeting established standards, including any legal licensing Residential Treatment facility requirements of the state or locality in which it operates.

Substance Use Disorder – means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Terminally Ill Person – means a person with an estimated life expectancy of 6 months or less, as attested by the Physician treating the illness.

SECTION V. COVERED PRESCRIPTION DRUG BENEFITS

A. How to Obtain Prescription Drugs

Prescription Drug Benefits are provided through CaremarkPCS Health, L.P. It is important to use Tier 1 Retail Pharmacies within the CVS Caremark Network in order to receive the maximum benefits available under the Plan. Prescription Drug Benefits will be paid as shown in the Summary of Prescription Drug Benefits.

1. **CVS Caremark Network**

   The CVS Caremark Network includes more than 64,000 national retail pharmacies that have contracted with CVS Caremark to provide Prescription Drugs at negotiated discounted rates. When you present your Prescription Order to a CVS Caremark Network Pharmacy, Prescription Drugs for up to a 30-day supply will be paid subject to the applicable Coinsurance and minimum and maximum Copays as shown in the Summary of Prescription Drug Benefits based on whether they are filled at a Tier 1 Retail Pharmacy or a Tier 2 Retail Pharmacy. All CVS Caremark Network pharmacies are Tier 2 Retail Pharmacies other than those specifically shown in the Summary of Prescription Drug Benefits as Tier 1 Retail Pharmacies.

   Under the Maintenance Choice Program, if you have a Maintenance Choice Prescription filled at a CVS retail pharmacy, you will pay the Mail Order Copay instead of the Retail Copay. A “Maintenance Choice Prescription” is a prescription for more than a 30-day supply of drugs covered under the Plan, excluding drugs obtained through the CVS Caremark Specialty Pharmacy.

2. **Tier 1 Retail Pharmacy**

   A Tier 1 Retail Pharmacy is a pharmacy that has contracted directly with the Plan Administrator to provide Prescription Drugs at negotiated discounted rates. When you present your Prescription Order to a Tier 1 Retail Pharmacy, Prescription Drugs for up to a 30-day supply will be paid subject to the applicable Coinsurance and minimum and maximum Copays as shown in the Summary of Prescription Drug Benefits. Long-term “maintenance" medications can be purchased through Tier 1 Retail Pharmacies (other than CVS retail pharmacies) for up to a 30-day supply with no refill limits.

3. **Non-Network Pharmacy**

   When you present your Prescription Order to a pharmacy other than a CVS Caremark Network Pharmacy, you will be required to make full payment for Prescription Drugs at the time of purchase. You will be responsible for filing claims directly with the Claims Administrator and will be reimbursed at 50% of the equivalent CVS Caremark Network Pharmacy, subject to the applicable Deductible as shown in the Summary of Prescription Drug Benefits. You will also be responsible for any difference between the CVS Caremark Network Pharmacy price and the Non-Network Pharmacy price.

   The Deductible must be satisfied once each calendar year by each covered person.

4. **Mail Order**

   When you submit your Prescription Order through the CVS Caremark Mail Order Program, Prescription Drugs for up to a 90-day supply will be paid subject to the applicable Coinsurance and minimum and maximum Copays as shown in the Summary of Prescription Drug Benefits.

Long-term “maintenance” medications for more than a 30-day supply must be purchased through the CVS Caremark Maintenance Choice Program.

5. **Specialty Pharmacy**

CVS Caremark Specialty Pharmacy services are provided by the Disease Management Division of CVS Caremark, and can be reached by phone toll free at 1-800-237-2767. This program is specifically designed to meet the needs of covered persons with chronic disorders such as:

- Alphal-Antitrypsin Deficiency, or Genetic Emphysema
- Cystic Fibrosis
- Growth Hormone Deficiencies
- Hemophilia/Von Willebrand Disease
- Immune Disorders
- Hepatitis C
- Rheumatoid Arthritis
- Respiratory Syncytial Virus (RSV)
- Psoriasis
- Cancer
- Multiple Sclerosis

These high-dollar, biotech medications must be obtained through the CVS Caremark Specialty Pharmacy. Physicians will submit and receive reimbursement for the charges associated with the administration of the drug through the Medical Benefits.

Specialty Copay Card Assistance

You may qualify for copay assistance programs offered by third party specialty medication manufacturers which could lower your out-of-pocket costs for those medications. Under many of these programs, your responsibility toward your Copay may be reduced to less than the Specialty Copay amount shown in the Summary of Prescription Drug Benefits for up to a 30-day supply. The reduced Copay amount will count toward your Out-of-Pocket Maximum.

CVS Caremark’s Specialty Pharmacy care management process will provide you the support and resources you need, including helping you pursue any available third party copay assistance program. If you choose not to participate in the care management process, you will not qualify for the third party copay assistance program.

Eligibility for third party copay assistance programs is dependent on the applicable terms and conditions required by that particular program and are subject to change. Copay assistance programs cannot be used with any government payer plan.

The available specialty copay assistance programs are subject to change, and reduced Copays are not guaranteed.

6. **Out-of-Pocket Maximum**

The Out-of-Pocket Maximum amount as shown in the Summary of Benefits applies separately to each covered person once during each calendar year. The Family Out-of-Pocket Maximum will be satisfied for the calendar year after two (2) or more covered persons have collectively incurred this amount; however, no individual covered person will be required to exceed the Individual Out-of-Pocket Maximum for a calendar year.

The Prescription Drug Benefits Out-of-Pocket Maximum can be met by payments of Coinsurance and Copay amounts for Prescription Drugs obtained through CVS Caremark Network Pharmacies. When the Out-of-Pocket Maximum has been met, the Plan begins to pay 100% of Covered Prescription Drug expenses (up to the applicable CVS Caremark Network Pharmacy price).

The Prescription Drug Out-of-Pocket Maximum cannot be met by non-covered expenses, penalties, or Coinsurance and Deductible amounts for Prescription Drugs obtained through Non-Network Pharmacies. The Prescription Drug Benefits Out-of-Pocket Maximum is separate from the Medical Benefits Out-of-Pocket Maximum. This means expenses for Medical Benefits do not count toward the Prescription Drug Out-of-Pocket Maximum.

B. Coordination with Medical Benefits

The Prescription Drug Benefits Deductible, Coinsurance or Copays under this Section V cannot be reimbursed through your Medical Benefits. In addition, they do not apply to your Deductibles or Out-of-Pocket Maximums under the Medical Benefits. There is no Coordination of Benefits under the Prescription Drug Benefits program.

C. Limitations and Exclusions - Prescription Drugs

In addition to the limitations and exclusions in the General Limitations and Exclusions in Section VIII, the following limitations and exclusions apply to the Covered Prescription Drug Benefits Section:

Limitations

1. Fertility drugs require an approved medical diagnosis and are limited to a $5,000 Lifetime Maximum Benefit through the Mail Order Program only.
2. Long-term “maintenance” medications must be purchased through Tier 1 Retail Pharmacies (other than CVS retail pharmacies) or the CVS Caremark Maintenance Choice Program. These medications are limited to one (1) initial fill and one (1) refill through any other retail pharmacy.
3. Tobacco cessation medications are only available for covered persons enrolled in the Tobacco Cessation Program. Approved nicotine replacement therapies are only available for covered persons enrolled in the Tobacco Cessation Program after the covered person has exhausted the initial supply of approved nicotine replacement therapy provided by Optum.
4. Coverage for hypnotic, narcotic, migraine, anti-emetic, and covered compound medications are subject to limited quantities and prior authorization.
5. Certain medications are subject to step therapy or prior authorization if a more cost-effective alternative is available.

Exclusions

- Investigational or experimental drugs
- Non-medicinal substances and over-the-counter medications except for 1) over-the-counter approved nicotine replacement therapies purchased pursuant to a prescription after the covered person has exhausted the initial supply of approved nicotine replacement therapy provided by Optum, and 2) over-the-counter medications and supplies to comply with the Affordable Care Act
- Charges for the administration or injection of any drug
- Prescription Drugs for a non-FDA approved purpose or dosage
- Prescription Drugs for personal enhancement – athletic or intellectual performance; hair growth; impedance of the aging process; weight management or weight reduction; enhancement of sexual performance, satisfaction or gratification
- Prescription Drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido
- Prescription Drugs to treat tobacco addiction, other than to covered persons enrolled in the Tobacco Cessation Program
- Non-sedating antihistamines and proton pump inhibitors
- Prescription refilled in excess of the number specified by the Physician
- Medication not requiring a Prescription Order
- A non-legend patent or proprietary medicine

- Medication dispensed by a facility
- Replacement of lost medication
- Bulk powders, proprietary bases, bulk nutrients, and bulk compounding agents

Some drugs that are excluded from coverage under the Plan may be available for a discount from CVS Caremark Network Pharmacies.

D. Definitions

Prescription Drug – means a drug or medicine which can only be obtained by a Prescription Order, or 1) an over-the-counter approved nicotine replacement therapy obtained with a Prescription Order after the covered person has exhausted the initial supply of approved nicotine replacement therapy provided by Optum, and 2) over-the counter medications and supplies to comply with the Affordable Care Act.

Prescription Order – means a written order for a Prescription Drug issued by a Physician within the scope of his or her professional license.

SECTION VI. COVERED DENTAL BENEFITS

The dental network through Delta Dental is a passive network. This means you can use any dental provider you choose and still receive coverage. However, if you use a Delta Dental provider, you will receive Covered Expenses at a discounted rate. In addition, Delta Dental providers will not balance bill for any difference between the billed charge and the Network Fee Schedule amount.

Delta Dental offers two provider networks: a PPO Network and a Premier Network. The PPO Network offers a more limited network of dentists but with greater discounts in what they charge. The Premier Network offers a larger network of dentists but with a smaller discount in their fees.

If you do not use a PPO Network or Premier Network dentist, the Plan pays up to the Premier Network Fee Schedule amount, and you will have to pay any charges above this amount.

A. Covered Expenses

Dental Benefits are those services or supplies provided by a Physician or Dentist when required for the prevention, diagnosis or treatment of the teeth and supporting tissues or structures. Benefits will be paid for Covered Expenses as shown in the Summary of Dental Benefits and will not exceed the maximums shown or the Network Fee Schedule, whichever is less. Covered Dental Benefits are also subject to the Pre-treatment Estimate of Benefits and Alternative Treatment Plan provisions in this Section VI. For purposes of this Covered Dental Benefits Section, Dental Benefits include only the following:

Core Plan

Preventive and Diagnostic Dental Services

- Routine oral examinations limited to two (2) per covered person per calendar year.
- Prophylaxis, including cleaning and polishing limited to two (2) per covered person per calendar year. A prophylaxis allowance will be made for a full mouth debridement or periodontal maintenance service; however, you will be responsible for any difference between the Network Fee Schedule amount for a full mouth debridement or periodontal maintenance service and the Network Fee Schedule amount for a prophylaxis service. Any combination of cleanings are limited to two (2) per covered person per calendar year.
- Dental x-rays, including full mouth x-rays, limited to one (1) in any period of 60 consecutive months; supplementary bitewing x-rays, limited to two (2) per calendar year; and such other dental x-rays and/or diagnostic photographs required in connection with the diagnosis of a specific covered condition which requires treatment.
- Emergency palliative treatment.
- Topical fluoride application for covered Dependent children under 19 years of age limited to one (1) treatment per person per calendar year.
- Space maintainers that replace prematurely lost teeth for covered Dependent children under 19 years of age.
- Application of pit and fissure sealants for posterior teeth, limited to one application per tooth every three (3) years for covered Dependent children under 14 years of age.

Basic Dental Services

- Simple extractions.
- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth.

Buy-Up Plan

Preventive and Diagnostic Dental Services

- Routine oral examinations limited to two (2) per covered person per calendar year.
- Prophylaxis, including cleaning and polishing limited to two (2) per covered person per calendar year.
- Dental x-rays, including full mouth x-rays, limited to one (1) in any period of 60 consecutive months; supplementary bitewing x-rays, limited to two (2) per calendar year; and such other dental x-rays and/or diagnostic photographs required in connection with the diagnosis of a specific covered condition which requires treatment.
- Emergency palliative treatment.
- Topical fluoride application for covered Dependent children under 19 years of age limited to one (1) treatment per person per calendar year.
- Space maintainers that replace prematurely lost teeth for covered Dependent children under 19 years of age.
- Application of pit and fissure sealants for posterior teeth, limited to one application per tooth every three (3) years for covered Dependent children under 14 years of age.

Basic Dental Services

- Extractions, including surgical extraction of bone impacted teeth.
- Oral surgery.
- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth.
- General anesthesia and IV sedation when Medically Necessary and administered in a dental office in connection with oral or dental surgery.
- Nitrous oxide.
- Surgical and non-surgical treatment of periodontal tissues, periodontal scaling, or other diseases of the tissues of the mouth.
- Endodontic treatment, including root canal therapy and pulpotomy.
- Injection of antibiotic drugs by the attending Physician or Dentist.
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture, limited to one relining or rebasing in any period of 36 consecutive months.
- Occlusal guard limited to one (1) in any period of 36 consecutive months.

Major Dental Services

- Initial installation of fixed bridgework (including inlays and crowns as abutments) to replace natural teeth extracted or to replace congenitally missing natural teeth.
- Initial installation of partial or full removable dentures (to include any adjustments during the six month period following installation) to replace natural teeth extracted.
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

  - The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

  NOTE: The Plan will cover only one replacement for a denture or bridgework that cannot be made serviceable once every five (5) years. The existing denture (full or partial) must be certified

by the Physician or Dentist to be at least five (5) years old at the time of replacement. Temporary dentures are not covered.

- Temporomandibular Joint Dysfunction (TMJ) and Related Care. (Refer to Definitions in this Section).
- Dental implantology (implants).
- Inlays, onlays or crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive Caries or fracture, cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite restoration.

  NOTE: The Plan will cover only one replacement for a crown that cannot be made serviceable once every five (5) years. The existing crown must be certified by the Physician or Dentist to be at least five (5) years old at the time of replacement.

Orthodontic Dental Services

Orthodontic dental services include these component services for covered Dependent children under 19 years of age:

- The initial and subsequent installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and its attendant sequelae through the correction of malposed teeth.
- In cases which treatment was started prior to the effective date of coverage under the Plan, Covered Expenses are payable for charges incurred on or after the effective date of coverage.

B. Coordination with Medical Benefits

The Dental Benefits Deductible and Coinsurance under this Section VI cannot be reimbursed through your Medical Benefits. In addition, they do not apply to your Deductibles or Out-of-Pocket Maximums under the Medical Benefits.

C. How Benefits are Paid

This Section describes how the coverage under the Dental Benefits portion of the Plan works, and how Covered Expenses for Dental Benefits are paid. As noted above, the Plan will not pay in excess of the Network Fee Schedule amount for any supply or service and greater discounts are available for Delta Dental providers. Providers who are not Delta Dental providers can balance bill you for any amount in excess of the Network Fee Schedule amount. The Plan pays a portion of Covered Expenses after any applicable Deductible up to the applicable Maximum Benefit amount shown in the Summary of Benefits.

The amount of the per Individual Deductible is shown in the Summary of Benefits. The Plan will not begin to pay benefits for Covered Expenses for an Individual in any calendar year until the Deductible is satisfied. The Deductible amount applies separately to each covered person once during each calendar year. The Deductible can be satisfied at either a Delta Dental or non-Delta Dental provider.

Once any applicable Deductible is satisfied, the Plan pays a percentage of Covered Expenses, up to any specified Maximum Benefit amount based on the Network Fee Schedule. The percentage the Plan pays varies, depending on the type of service as shown in the Summary of Benefits. When the Plan payment is less than 100%, the remaining percentage is your Coinsurance.

D. Pre-Treatment Estimate of Benefits

If a Course of Treatment can reasonably be expected to involve Covered Dental Benefits of $200 or more, a description of the procedures to be performed and an estimate of the Dentist's or Physician's fees should be filed with Delta Dental prior to the commencement of the Course of Treatment.

Delta Dental will notify you and the Dentist or Physician of the benefits payable based on such Course of Treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or Course of Treatment that may be performed for the dental conditions concerned in order to accomplish the desired results based on accepted standards of dental practice.

If a description of the procedures to be performed and an estimate of the Dentist's or Physician's fees are not submitted in advance, Delta Dental reserves the right at the time claim is filed, to make a determination of benefits payable taking into account alternate procedures, services or Course of Treatment, based on accepted standards of dental practice. To the extent verification of Covered Dental Benefits cannot reasonably be made by Delta Dental, the benefits for the Course of Treatment may be for a lesser amount than would otherwise have been payable.

This pre-treatment estimate will not apply to Courses of Treatment under $200, or to emergency treatment, routine oral examinations, x-rays, prophylaxis and fluoride treatments.

E. Proof of Claim

Delta Dental reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for Covered Dental Benefits. As a part of the basis for determining benefits payable, Delta Dental may require submission of x-rays and other appropriate diagnostic and evaluative materials. When these materials are unavailable, and to the extent that verification of Covered Dental Benefits cannot reasonably be made by Delta Dental based on the information available, benefits for the Course of Treatment may be for a lesser amount than that which otherwise would have been payable.

F. Alternative Treatment Plan

There is often more than one service or supply that can be used to treat a dental problem or disease. In considering the benefits allowed on a claim or advance treatment review, these different methods of treatment and materials will be considered. Covered Dental Benefits will be limited to the Network Fee Schedule amount.

G. Limitations and Exclusions - Dental

In addition to the limitations and exclusions in the General Limitations and Exclusions in Section VIII, the following limitations and exclusions apply to the Covered Dental Benefits Section:

Limitations - Dental

1. In all cases which there are optional techniques carrying different fees, the Plan will only be liable for the treatment carrying the lesser fee.
2. In the event a covered person transfers from the care of one Dentist to that of another Dentist during the Course of Treatment, or if more than one Dentist renders services for one dental procedure, the Plan will be liable for no more than the amount the Plan would have been liable for had but one Dentist rendered the service.

Exclusions - Dental

- Services other than those specifically shown as Covered Dental Benefits.
- Charges for treatment by other than a Dentist or Physician, except that cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the Dentist.
- Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the ten upper and lower anterior teeth.
- Charges for the replacement of lost, missing, or stolen prosthetic device.
- Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the covered person's employer.
- Charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending Dentist or Physician.
- Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature.
- Charges for services or supplies received as a result of dental disease, defect or Injury due to an act of war, declared or undeclared.
- Charges for any duplicate prosthetic device or any other duplicate appliance.
- Charges for oral hygiene and dietary instruction.
- Charges for a plaque control program.
- Charges for services or supplies that are partially or wholly cosmetic in nature or directed toward a cosmetic end, including charges for personalization or characterization of dentures.
- Charges for periodontal splinting (stabilizing or immobilizing teeth to gain strength and/or facilitate healing).
- Treatment of Injury to teeth arising from or in the course of any employment.
- Charges for appliances, restorations and procedures to alter vertical dimension or restore occlusion.
- Charges for orthognathic surgery.
- Charges for cosmetic or reconstructive procedures, and any related services or supplies which alter appearance, but do not restore or improve impaired physical function, except when performed for the treatment of a birth defect in a child if the treatment occurs on or before the date a child reaches skeletal maturity as determined by the American Medical Association or other appropriate medical society.
- Charges for any dental services if benefits or services for all or any part of the expenses for such services are provided under any employer coverage or prepayment plans providing Hospital, surgical and medical services or benefits.
- Charges for cone beam imaging.

H. Definitions

For purposes of this Section only, the terms used shall have the following meanings:

Caries – means a disease of progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

Course of Treatment – means a planned program of one or more services or supplies rendered by one or more Dentists or Physicians, for the treatment of a covered dental condition diagnosed by the attending Dentist or Physician as a result of an oral examination. The course of treatment begins on the date the Dentist or Physician first renders a service or supply to correct or treat such covered diagnosed condition.

Covered Dental Benefits – means those services or supplies listed in this Section VI which are provided by a Physician or Dentist when required for the prevention, diagnosis or treatment of diseases or conditions of the teeth and supporting tissues or structures.

Dentist – means an individual who is duly licensed to practice dentistry.

Network Fee Schedule – means a predetermined fee or payment based on the contracts and payment methods between Delta Dental and PPO Network and Premier Network dentists. These amounts and payment methods may vary from place to place. Services rendered by non-PPO and non-Premier Network Dentists will be reimbursed up to the Network Fee Schedule amount for Premier Network Dentists.

Orthognathic Surgery – means the surgery to alter relationships of dental arches and/or supporting bones, usually accomplished with orthodontic therapy.

Physician – means a licensed physician authorized to perform the particular dental service rendered.

PPO Network – means a network of Dentists through Delta Dental that agree to accept the Network Fee Schedule amount as payment in full for the services they provide. This network offers a more limited network of dentists but with greater discounts in their fees than the Premier Network.

Premier Network – means a network of Dentists through Delta Dental that agree to accept the Network Fee Schedule amount as payment in full for the services they provide. This network offers a larger network of dentists but with a smaller discount in their fees than the PPO Network.

TMJ and Related Care – Surgical and non-surgical care connected with the detection or correction of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves, and other tissues related to that joint.

SECTION VII. COVERED VISION BENEFITS

Vision Benefits are provided through VSP. It is important to use the VSP network of providers in order to receive the maximum benefits available under the Plan. However, through the VSP Open Access network, you can use your vision benefit at any Eyecare Provider. Ask your Eyecare Provider if they will accept direct payment from VSP. If so, have them contact VSP at 800-877-7195. The Eyecare Provider will obtain your benefit information, collect the necessary Copay and any balance above your Open Access schedule of allowances. They can then submit the claim on your behalf to VSP. This means you won't need to pay the entire bill up front and submit a statement to VSP for reimbursement. If you do not use a VSP Provider, your benefit is reduced.

A. Covered Expenses

Covered Vision Benefits are those services or supplies provided by an Eyecare Provider when required for the prevention, diagnosis or treatment of visual acuity. Benefits will be paid for Covered Expenses as shown in the Summary of Vision Benefits and will not exceed the maximums shown. For purposes of this Covered Vision Benefits Section, Covered Expenses are not coordinated with other Plans and include only the following:

1. **Vision Examination**

   A vision examination, regardless of Medical Necessity, by an Eyecare Provider. The examination is covered in full subject to the Copay as shown in the Summary of Vision Benefits. A vision examination includes, but is not limited to, these component services:

   - A case history;
   - External examination of the eye and adnexa;
   - Opthalmoscopic examination;
   - Determination of refractive status;
   - Binocular balance testing;
   - Tonometry test for glaucoma, when indicated;
   - Gross visual fields, when indicated;
   - Color vision testing, when indicated;
   - Summary finding; and
   - Recommendations, including prescribing of corrective lenses.

2. **Prescribed Lenses and Frames**

   Prescribed lenses and frames, including directly related professional services. Single vision, lined bifocal, lined trifocal and high index lenses are covered in full subject to the Copay as shown in the Summary of Vision Benefits. You will be responsible for any amounts which exceed the Plan's allowance.

3. **Prescribed Contact Lenses**

   Prescribed contact lenses, including directly related professional services. Contact lenses must be ophthalmic corrective lenses and are subject to the applicable Copay as shown in the Summary of Vision Benefits. You will be responsible for any amounts which exceed the Plan's allowance. The allowance applies to the cost of your contact lens exam and contact lenses.

B. Coordination with Medical Benefits

The Vision Benefits Copays under this Section VII cannot be reimbursed through your Medical Benefits. In addition, they do not apply to your Out-of-Pocket Maximums under the Medical Benefits. There is no Coordination of Benefits under Vision Benefits.

C. Limitations and Exclusions - Vision

In addition to the limitations and exclusions in the General Limitations and Exclusions in Section VIII, the following limitations and exclusions apply to the Covered Vision Benefits Section:

Limitations

1. Benefits are limited to **either** one pair of eyeglasses (prescribed lenses and frames) **or** prescribed contact lenses, **but not both**.
2. Benefits are limited to one vision examination once every 12 months.

Exclusions

- Services other than those specifically shown as Covered Vision Benefits.
- Lenses and/or frames which exceed the Plan's allowance.
- Lens types and treatments which enhance the appearance, durability or function of your glasses.
- Plano lenses (less than a ±.50 diopter power).
- Additional pair of glasses in lieu of bifocals.
- Replacement of lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
- Diagnostic services other than those provided as components of a vision examination, and medical or surgical treatment.
- Artificial eyes.
- Medical or surgical care of eye – Illness or Injury.
- Any special or unusual services including visual training, orthoptics, low vision aids, reading rate or comprehensive studies.
- Any Covered Vision Benefits or supplies ordered before you become covered for benefits, or after the date your coverage ends.
- Any services rendered by a provider who is not an Eyecare Provider.

D. Definitions

Covered Vision Benefits – means those services or supplies listed in this Section which are provided by an Eyecare Provider when required for the prevention, diagnosis or treatment of visual acuity.

Eyecare Provider – means a duly licensed Ophthalmologist or Optometrist.

VSP Provider – means an Eyecare Provider who has contracted through VSP to provide vision benefits through the Plan.

SECTION VIII. GENERAL LIMITATIONS AND EXCLUSIONS

The following are the limitations and exclusions from coverage under the Plan. Other limitations and exclusions may apply, and if so, will be described elsewhere in this Summary Plan Description.

- Drugs, services, operations, procedures, treatments, equipment, devices, implants or supplies that are not Medically Necessary, except to the extent that they constitute Preventive Care Services as otherwise recognized and covered by the Plan in accordance with the preventive care services requirements of the Affordable Care Act.
- Expenses in connection with a bodily Injury or Illness arising from or in the course of any employment, unless (i) the covered person has taken all reasonable efforts to claim benefits under a workers' compensation policy issued in and effective for the covered person's state of employment in accordance with applicable claim filing requirements (including any timely filing limit rules), but coverage has been wholly denied under that policy, or (ii) the expenses are incurred by a covered Dependent who is self-employed and cannot legally obtain workers' compensation coverage.
- Expenses incurred before coverage begins or after coverage ends.
- Medical examinations not necessary for the treatment of an Injury or Illness, except covered Preventive Care Services.
- Hearing aids or the fitting of hearing aids, other than cochlear implants that are Covered Expenses.
- Cosmetic or reconstructive procedures, and any related services or supplies, which alter appearance but do not restore or improve impaired physical function, except when performed for the:

  (i) repair of defects resulting from an accident;
  (ii) replacement of diseased tissue which has been surgically removed;
  (iii) treatment of a birth defect in a child if the treatment occurs on or before the date the American Medical Association or other appropriate medical society considers a child to have reached skeletal maturity; or
  (iv) breast reconstruction following a mastectomy, including reconstruction of the other breast to produce symmetry.

- Operation or treatment of the teeth or the supporting tissues of the teeth except (i) tumors, (ii) treatment of accidental Injury to natural teeth (including their replacement) due to an accident (provided treatment begins within 6 months of accidental Injury and is completed within 12 months of accidental Injury), and (iii) as designated under the Covered Dental Benefits in Section VI.
- Outpatient Hospital charges for Dental care, except for children under age 5, or for patients of any age, if Medically Necessary.
- Operation or treatment in connection with the fitting or wearing of dentures and dental implants.
- TMJ and Related Care except as designated under the Covered Dental Benefits in Section VI, other than surgical correction of the TMJ required as a result of an accidental Injury, (provided treatment begins within 6 months of accidental Injury and is completed within 12 months of accidental Injury).
- Charges that exceed the Network Fee Schedule amounts or other fee standards applied by the Claims Administrator where the Network Fee Schedule does not apply.
- Charges for counseling, including but not limited to: group, marital, family, educational, social, sexual, occupational or religious, other than counseling that qualifies as covered Preventive Care Services or is specifically identified as a Covered Expense.
- Ambulance services when the patient could be safely transported by means other than ambulance, whether or not other transportation is available; air ambulance services when the patient could be safely transported by ground ambulance; ambulance transportation from one facility to another, unless Medically Necessary; and ambulance transportation from the Hospital to the patient's home.
- Items used for personal comfort or convenience, personal hygiene, or other nontherapeutic purposes. (For example, the Plan does not cover telephones, television, and guest meals while in a facility if they are charged separately from the cost of the room).

- Care or treatment of learning disability, except Medically Necessary services required to diagnose such conditions.
- Charges for alternative care services and supplies, including but not limited to: acupuncture, acupressure, holistic and homeopathic treatment, massage or massage therapy (except when considered eligible and rendered by a Chiropractor or Physical Therapist), rolf therapy, dance therapy, movement therapy, applied kinesiology, naturopathy, faith healing, hypnosis, behavior modification, biofeedback, hypnotherapy and electronarcosis.
- Charges for preparing medical reports, itemized bills or claim forms; appointments scheduled but not kept; shipping and handling; postage; interest; sales tax (unless required by law); or finance charges that a Physician might bill.
- Growth hormone therapy, except as designated under Covered Prescription Drug Benefits in Section V.
- Over-the-counter drugs, supplies and medications, vitamins, minerals, food supplements, nutritional supplements, or special diets except as required to comply with the Affordable Care Act.
- Prescription drugs and medications, except as designated under Covered Prescription Drug Benefits in Section V.
- National Comprehensive Cancer Network (NCCN), category 2B injectable drugs.
- Visits or consultations that are not in person (i.e., telephone or internet), whether initiated by you or the Physician, other than covered telemedicine services rendered by approved provider.
- Treatment of tobacco addiction, including supplies for addiction to tobacco, tobacco products, or nicotine substitutes, other than for covered persons enrolled in the Tobacco Cessation Program or covered under Preventive Care Services.
- Immunizations, other than as recommended under Preventive Care Services.
- Charges for services or supplies for which no charge is made that you are not required to pay.
- Expenses for treatment or surgery for obesity, weight reduction or weight control regardless of any underlying conditions complicated by excessive body weight, other than as recommended under Preventive Care Services; surgical procedures, including but not limited to gastric bypass and lap band.
- Assistant surgeon charges, when not Medically Necessary.
- Charges for admission to a Hospital on a Friday or Saturday other than for an Emergency admission or when performed surgery has taken place.
- Home Health Care charges for services or supplies not included in the Home Health Care Plan.
- Private Duty Nursing services, unless otherwise covered under the Home Health Care Plan.
- Residential treatment services, unless authorized by psychiatric case management administrator.
- Charges for Custodial Care including, but not limited to services or supplies furnished by an institution which is primarily a place of rest or a place for the aged, or youth homes, boarding schools, or any similar institution.
- Hospice Care charges for services not included in the Hospice Care Plan.
- Charges for services or supplies not specifically listed under Covered Expenses in Sections IV, V, VI, and VII.
- Artificial insemination or in vitro fertilization services rendered by a provider other than an In-Network Progyny Fertility Provider and services that are not pre-authorized.
- Fertility charges for services or supplies not specifically listed under Covered Expenses in Section IV including donor sperm and donor oocytes or embryos and charges associated with care of the donor required for donor oocytes retrievals or transfers or gestational carriers (surrogacy); charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to fees for laboratory tests; fertility expenses for dependent children; home ovulation prediction kits; non-genetic disorder reproductive treatments done for purposes of gender selection; fertility services and supplies furnished by an out-of-network provider; fertility services following a voluntary sterilization procedure; and pre-implantation genetic diagnosis expenses.
- Services and supplies for or in connection with erectile dysfunction, regardless of its origin, or procedures to restore or establish sexual function.
- Cosmetic treatment of gender dysphoria.

- Education or training, except as designated under Covered Medical Benefits in Section IV.
- Equipment or supplies made or used for physical fitness, athletic training or general health up-keep.
- Usual and normal home medical supplies or first aid items.
- Procedures to reverse sterilization.
- Experimental and/or Investigational Services or Supplies and any related expenses.
- Any item or service that is the subject of a phase I, II, III, or IV clinical trial.
- Hyperalimentation or Total Parenteral Nutrition (TPN); except as provided under Covered Expenses in Section IV.
- Artificial or non-human transplants.
- Vision services and expenses for vision therapy (eye exercises) for the treatment of learning disabilities, to improve visual performance, strengthen eye muscles, retrain eye responses to visual stimuli, or relieve pain and discomfort associated with, but not limited to, strabismus (cross-eyed, wall-eyed), amblyopia (lazy eye), convergence abnormalities (double vision) other than convergence insufficiency, reading disorders (eye coordination), and dyslexia (transposition of letters in reading and seeing). Refer to Covered Medical Benefits in Section IV and Covered Vision Benefits in Section VII, as applicable.
- Procedures to correct refractive errors/astigmatism and reversals or revisions of procedures which alter the refractive character of the eye.
- Aids or devices that assist with verbal or nonverbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Treatment of Injury or Illness which is occasioned by war, declared or undeclared, or caused or aggravated by your military service.
- Services, supplies, examinations, reports, or appearances in connection with legal proceedings or court ordered or court-related services.
- Services and supplies for treatment of an Illness or Injury sustained while committing an illegal act, other than moving violations, treatment arising from or related to a health factor such as depression or mental illness, or an act of domestic violence against the covered person.
- Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining medical services.
- Charges for transportation, lodging and food associated with a transplant rendered by any center other than an In-Network Transplant Center (or an In-Network Provider, if an In-Network Transplant Center does not offer the requested transplant as described in the Organ and/or Tissue Transplant Benefit portion of Section IV Covered Medical Benefits).
- Transplant donor charges if the recipient is not a covered person under the Plan.
- Services and supplies resulting from complications of a non-covered procedure and a procedure limited through Maximum Benefits.
- Services and supplies for readmissions due to provider errors.
- Services incurred for or in connection with surrogacy, other than as required by the Affordable Care Act and the Pregnancy Discrimination Act.
- Prolotherapy.
- Craniosacral/cranial therapy.
- Charges for abdominoplasty and panniculectomy services, other than medically necessary services that meet the Claims Administrator's coverage criteria.
- Charges made by any Physician who is a member of your family or your Dependent's family.
- Maternity and pregnancy-related services for covered Dependent children, other than as required by the Affordable Care Act as Preventive Care Services.
- Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest; charges for abortions performed by pharmaceutical methods.
- Wigs, including following chemotherapy or radiation therapy.

- Charges made by an individual or entity that is not a Physician, Convalescent/Skilled Nursing Facility, Psychiatric Day Facility, Neurologic Rehabilitation Facility, Residential Treatment facility or Hospital as defined under the Plan.
- Charges made by an individual or entity, including but not limited to Physicians, who is required to maintain a license to perform services but (1) is not licensed or (2) has had his license suspended, revoked or otherwise terminated for any reason or (3) has a license that does not include services within its scope of treatment procedure or service provided.
- Charges in excess of the Plan Allowance.
- Respite Care.
- Routine Foot Care, including but not limited to cutting or removing of corns and calluses; trimming, cutting, clipping or debriding of nails; and other hygienic and preventive maintenance foot care, other than when required for prevention of complications associated with diabetes mellitus.

SECTION IX. GENERAL PROVISIONS THAT APPLY TO COVERED MEDICAL BENEFITS AND COVERED DENTAL BENEFITS

A. Coordination of Benefits

Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans -- including Medicare -- are paying. When a covered person is covered by this Plan and another plan, the plans will coordinate benefits when a medical or dental claim is received. The Prescription Drug and Vision Benefits do not have Coordination of Benefit provisions.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses.

1. **Benefit plan.** This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

   a) Group or group-type plans, including franchise or blanket benefit plans, whether insured or uninsured.
   b) Service plan contracts, group practice and other group prepayment plans.
   c) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
   d) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

   For purposes of the Coordination of Benefits provision, the term benefit plan does not include:

   a) An individual policy, except one which provides “no-fault” automobile insurance or is issued on a blanket or franchise basis. “No-fault” automobile insurance means coverage under which personal Injury benefits are paid as expenses accrue, without regard to fault.
   b) Any union sponsored or negotiated plan or employee benefit organization plan.
   c) An accidental injury policy provided through a school for athletic injuries, either on a 24-hour basis or on a “to and from school” basis.
   d) A Hospital indemnity plan except as allowed by law.
   e) Medicaid (Title XIX, Grants to States for Medical Assistance Programs).

   Notwithstanding the foregoing, this Plan is secondary to any group or individual no-fault or medical payments coverage. Any coverage provided herein is expressly subordinate to any group or individual no-fault or medical payments (auto or premises, nursing home and long-term care, disability income protection) coverage, whether such coverage is purchased as primary, secondary or excess.

   Whenever this Plan and any group/individual no-fault or medical payments coverage contain conflicting coordination of benefits (other insurance) clauses, the terms of this Plan must be given full effect. At the request of the Plan, a covered person shall assert a claim to these coverages.

   In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full.

   Plan – For purposes of the Coordination of Benefits provision, means all Medical and Dental Benefits provided by the Plan.

Allowable Expense – means an item of medical or dental expense which is usual and customary, or is listed in the Network Fee Schedule and for which the covered person is covered under one or more plans. In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Expense.

2. **Benefit plan payment order.** When two or more plans provide benefits for the same Allowable Expense, benefit payment will follow these rules:

   (a) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
   (b) Plans with a coordination provision will pay their benefits up to the Allowable Expense:
      (1) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) are determined before those of the plan which covers the person as a dependent.
      (2) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
      (3) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
      (4) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
         (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
         (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
      (5) When a child's parents are divorced or legally separated, these rules will apply:
         (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
         (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
         (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
         (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.
         (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
      (6) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. A new plan is not established when coverage by one carrier is replaced within one day by that of another.

(c) If a covered person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
(d) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

3. **Exceptions to Effect on Benefit Rules**

Medicare Parts A and B do not cover dental or vision care. Therefore, while the Plan includes coverage for dental or vision care not covered by Medicare, the Plan will pay these benefits as the primary payer. There is no coordination for Prescription Drug Benefits under this Plan.

When a covered person is eligible for Medicare, this Plan will pay benefits before Medicare for the covered medical expenses of:

a) an active Employee or the Dependent spouse of an active Employee who is age 65 or over;
b) an active Employee or the Dependent of an active Employee who is entitled to Medicare on the basis of a total disability;
c) an active Employee or the Dependent of an active Employee for the first 30 consecutive months of treatment for end-stage renal disease; or
d) a retired employee or the Dependent of a retired employee under age 65, for the first 30 consecutive months of treatment for end-stage renal disease or until age 65, whichever occurs first.

When the rules above do not apply, this Plan will pay its benefits for covered medical expenses only after Medicare has paid its benefits. Medicare will pay first for:

a) a retired employee or the Dependent of a retired employee age 65 or over;
b) an active Employee or the Dependent of an active Employee after the first 30 consecutive months of treatment for end-stage renal disease; or
c) a retired employee or the Dependent of a retired employee under age 65 who is eligible for Medicare due to total disability.

4. **Claims determination period.** Benefits will be coordinated on a calendar year basis. This is called the claims determination period. However, it does not include any part of a year which a person has no coverage under this Plan, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

5. **Right to receive or release necessary information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A covered person will give this Plan the information it asks for about other plans and their payment of Allowable Expenses.

6. **Facility of payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

7. **Rights of Recovery and Direct Payment.** We have the right to recover from other plans or persons any payments we have made which exceed those required by these provisions. We also have the right to make direct payment to plans or persons of amounts paid by them which should have been paid by us. Such payment will be deemed benefits paid under this Plan and will discharge our liability to the extent of the payment.

B. Acts of Third Parties (Subrogation/Reimbursement)

Plan benefits are not payable to or for a person covered under this Plan (including all Dependents) when the Injury or Illness to the covered person occurs through the act or omission of another person who is or may be liable to the covered person under tort law or for which the covered person is eligible for payment or reimbursement provided to the covered person by any party other than the Plan. However, the Plan Administrator may provide benefits for an Injury or Illness caused by or reimbursable by such other party. In addition, the Plan may provide benefits for an Injury or Illness which is later determined to be the fault of another party or reimbursable by such other party. The covered person, by receipt of benefits from the Plan, agrees to reimburse the Plan Administrator for receipt of any benefits if and when such person receives payment of any type or character for the Injury or Illness from any third party. The acceptance of benefits under this Plan constitutes the covered person's contractual agreement to reimburse the Plan in full any sums paid by the Plan for benefits from the recovery in any manner of any payment of any type or character for the Injury or Illness from any responsible third party. The Plan's right of first recovery exists even if the covered person has not been fully compensated or made whole, even if the covered person makes only a partial recovery of his/her damages, and even if the funds are held by another party for the benefit of the covered person. The "common fund" doctrine does not apply to any funds received by any attorney the covered person retains. The Plan will not reduce the amount of its claim for a covered person's litigation costs, attorney's fees or any other litigation expenses incurred by the covered person in making his/her recovery from the third party. The Plan would also not be compelled to pay a pro rata share of the aforementioned litigation costs or attorney's fees.

By electing to participate in the Plan and the acceptance of the benefits offered under it, a covered person agrees to the terms, conditions and obligations under this Section IX.B, including the covered person's duty not to prejudice the Plan's rights under this Section IX.B.; the covered person's duty to keep the Plan Administrator advised in writing of any circumstance where his or her Injury or Illness occurs through the act or omission of another person who is or may be liable to the covered person under tort law or for which the covered person is eligible for payment or reimbursement provided to the covered person by any third party; the covered person's duty to advise the Plan Administrator in writing of the receipt of any recoveries from such third party; and the covered person's waiver of the right to assert any equitable defenses against the Plan in the event the Plan asserts any of its rights under this Section IX.B.

The Plan Administrator may require that a covered person sign an acknowledgement of these terms, conditions and obligations prior to the payment of benefits. The Plan Administrator shall have such right to recover in full, in first priority, regardless of whether that person actually signs any such acknowledgement. This right to first priority cannot be waived or altered in any way unilaterally by the covered person. Any signed acknowledgement is deemed incorporated as part of this Plan. Construction of these terms, conditions and obligations, any acknowledgement thereof, and this Plan is to be governed by the Employee Retirement Income Security Act of 1974 (ERISA), notwithstanding any state or local law in conflict therewith.

By accepting benefits under this Plan, the covered person also automatically assigns to the Plan any rights the covered person may have to recover payments from any other party and the Plan has an equitable lien and/or constructive trust on any amount recovered by the covered person whether or not designated as a payment for medical, dental, or vision expenses or is designated in whole or in part as "pain and suffering" or "non-economic damages only," and regardless of whether such amount has been commingled with other funds. The Plan's right to recovery will not be reduced even if the recovery does not fully compensate the covered person, or the covered person was not made whole, for all losses sustained or alleged. Any so-called "make-whole" or "full-compensation" rule or doctrine is hereby explicitly rejected and disavowed. Such lien or trust shall extend to any funds held for the benefit of the covered person by any other party. Such lien or trust shall remain in effect until

the Plan is repaid in full. The Plan's recovery shall not be reduced by any portion of the covered person's attorney fees or legal expenses.

A covered person, by receipt of Plan benefits, further agrees the Plan shall have the right of subrogation to recover in full from any responsible person or business entity the full amount of any benefits provided by the Plan. In the event the Plan Administrator institutes a subrogation claim or action, the covered person agrees that claim or suit may, at Plan Administrator's election, be brought in the name of the covered person, the Plan or the Plan Sponsor, in a representative capacity for the Plan, and any such suit shall be initiated, conducted, settled, or compromised in the sole discretion of the Plan Administrator or its designee. The covered person, by receipt of benefits under this Plan, agrees to fully cooperate in the prosecution of such subrogation claim or suit. In such instances, the Plan Administrator shall bear its own attorney's fees in connection with said litigation. In the event the covered person shall retain his or her personal attorney in connection with such litigation, attorney's fees for such personal attorney shall be the sole responsibility of the covered person.

The Plan's right of full, first priority recovery, either by way of subrogation or right of reimbursement, may be from any funds the covered person, Dependent, or guardian receives or is entitled to receive from any other party, any liability or other insurance covering any other party, the insured's own uninsured motorist benefits, underinsured motorist benefits, homeowners and commercial premises coverage, any health payments, no-fault, school insurance coverages which are paid or payable, or payments of worker's compensation or other compensation for workplace injury benefits. The Plan's right of full, first priority recovery shall apply regardless of whether any liability for payment is admitted by any other party. The Plan's right of full, first priority recovery, shall apply regardless of whether the funds are held by the covered person, his or her legal representative, or any other person acting on behalf of the covered person or his or her legal representative.

The Plan may enforce this provision by requiring a covered person or his or her guardian to assert a claim to any of the foregoing coverages to which he/she may be entitled.

C. Dependents Previously Covered As Employees

Medical and Dental Benefits payable on behalf of a Dependent previously covered under the Plan as an Employee for Covered Expenses incurred during a period which began while the Dependent was eligible as an Employee shall not exceed the benefits that would have been payable during such period had the Dependent remained eligible as an Employee.

D. Recovery of Overpayment, Incorrect Payment, or Unsatisfied Cost Sharing

In the event of an overpayment or incorrect payment made to or on behalf of any entity, provider or person (whether by error, by subsequent processing, or otherwise) or in the event a person fails to satisfy a cost sharing requirement (in whole or in part) in due course. The Plan has an equitable lien and/or constructive trust on any such overpayment or incorrect payment. Further, the Plan has the right to recover the overpayment, incorrect payment, or unsatisfied cost sharing amount by any and all available legal means, including, without limitation, additional payroll withholdings; offset of future benefit payments to or on behalf of an entity, provider, or person; or suspension of future benefit payments to or on behalf of an entity, provider, or person until the overpayment, incorrect payment, or unsatisfied cost sharing amount is repaid. By accepting benefit payments under this Plan, any entity, provider, or person expressly consents to the application of this provision.

E. Prohibition on Assignment of Benefits

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, exception or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Sponsor finds that such an attempt has been made with respect to

any payment due or to become due to any covered person, the Plan Sponsor, in its sole discretion, may terminate the interest of such covered person, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such covered person, as the Plan Sponsor may determine, and such application shall be a complete discharge of all liability with respect to such benefit payment. A direct payment by the Plan to a provider makes the provider an intended third-party beneficiary under the Plan, and not an assignee.

SECTION X. CLAIMS PROVISIONS

A. Claim Payments

Claims procedures are implemented pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA).

B. Claims Filing Procedures

1. In most cases, a claim for benefits under the Plan will be filed on your behalf by the health care provider who furnishes services to you. If unusual circumstances arise in which you need to file a claim on your own behalf, forms for filing claims may be obtained from the appropriate Claims Administrator. Any claim you submit must include the name of the covered Employee, his or her member identification number, the name of the patient, and the Group Identification Number, if any. Whether a claim for Plan benefits is filed by you, by your health care provider or by someone else whom you authorize to act as your authorized representative, the claim must meet the requirements of this summary plan description, including the claims-filing policies and procedures of the Claims Administrator. All claims must be submitted in writing or in the equivalent electronic form under HIPAA Transactions Rules. The Plan has established and will enforce a one-year timely filing deadline for all claims for benefits under the Plan, meaning that you, your healthcare provider or any other authorized representative acting on your behalf must complete and return your claim to the Claims Administrator within one year from the date of service. However, In-Network Providers must submit claims within the time limits provided in their applicable provider contract, if shorter than one year. Claims are not payable if they are not submitted to the Claims Administrator within the applicable time limit.

2. When filing your claim, you must submit proof of each charge so it is extremely important that you secure copies of bills for all charges. All bills should be itemized, and the pharmacy bills for prescription items must include the prescription number and the name of the person for whom prescribed.

    - After you receive services, you should only file a claim if your provider does not file one for you. Medical and Dental Benefits for provider charges may be automatically paid to the provider. Automatic payment will not apply for Prescription Drugs and Vision Care Benefits.
    - In the event there is an overpayment made to you on your or your Dependent's claim (whether by error or by subsequent processing), recovery of the overpaid amount can be deducted from future claims presented for processing.
    - All benefits provided by the Plan will be paid within a reasonable period of time (subject to applicable U.S. Department of Labor claims regulations) following the Claims Administrator's receipt of a claim properly filed in accordance with the Claims Administrator's and the Plan's claims-filing policies and procedures. All benefits not otherwise payable to providers will be payable to the Employee, if living, otherwise to the estate of the Employee.
    - This Plan is not in lieu of and does not affect any requirement for Workers' Compensation Insurance.
    - You may use the services of an authorized representative to assist you with the claims process. The Plan has established rules and an approved form for designating an authorized representative for Medical Benefits claims – see the "Authorized Representative Designation" section below. The Claims Administrator for other benefits may establish rules for confirming the authorized status of any designated representative.

C. Claims Review Process

You or an authorized representative should send your completed claim form and any necessary information to the name and address of the appropriate Claims Administrator noted on the form.

Urgent Care Claims

In the event of a claim that involves urgent care, you will be notified whether your claim has been approved or denied as soon as possible, taking into account the medical exigencies, but in any event within 72 hours after the Claims Administrator receives your claim. If your claim is incomplete, the Claims Administrator will notify you as soon as possible, taking into account the medical exigencies, but in any event within 24 hours after the Claims Administrator has received the claim of the additional information you need to complete your claim and the deadline for providing this information. The deadline for providing the additional information will not be less than 48 hours after you are notified. If additional information is requested, you will be notified of the claim determination within 48 hours after the earlier of (1) the Claims Administrator's receipt of the information or (2) the deadline for submitting the additional information. Notification may be provided orally or in writing. In the case of oral notification, you will receive a formal written notice within three days after the oral notice. A claim for urgent care is a claim for which waiting (i) could result in serious jeopardy to the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be managed without the treatment that is the subject of the claim. The Plan will defer to a determination by the attending Physician that a claim is for urgent care.

Concurrent Care Decisions

Special rules apply where the Claims Administrator has approved an ongoing course of health care treatment either for a specific period of time or for a specific number of treatments.

A reduction or termination of the course of treatment before the approved time period or number of treatments will be considered a claim denial (except when it is done because of plan amendment or termination). In this case, the Claims Administrator will notify you in advance so you can appeal the decision before the benefit is reduced or terminated.

You may request to extend the course of treatment beyond the approved time period or number of treatments. If this involves urgent care, the Claims Administrator will notify you whether your request has been approved or rejected as soon as possible, taking into account the medical exigencies, but in any event within 24 hours of receiving your request, as long as you make your request at least 24 hours before the approved time period or number of treatments expires.

Pre-Service Claims

A pre-service claim is any request for approval of a benefit where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care (for example for pre-certification). The Claims Administrator will notify you whether a pre-service claim has been approved or denied within 15 days of receiving your claim. If you fail to follow the Plan's procedures for filing a pre-service claim, you'll be notified that you did not follow the procedures and be provided with an explanation of what the proper procedures are. You'll be notified within five days after the original claim is filed.

The original 15-day period to respond to your claim may be extended for another 15 days if you are notified, before the end of the original 15-day period, that the extension is necessary due to matters beyond the control of the Claims Administrator. The notice will explain the reason for the extension and when the Claims Administrator expects to rule on your claim. If the extension is needed because

you failed to provide the information needed to decide the claim, the notice will tell you what additional information you need to furnish. In this event, you will have 45 days from the date you receive the notice to provide the additional information.

Post-Service Claims

Post-service claims refer to all other claims that cannot be categorized as pre-service claims. The Claims Administrator will notify you whether a post-service claim has been denied within 30 days of receiving your claim. This period may be extended for another 15 days if you are notified, before the end of the original 30-day period, that the extension is necessary due to matters beyond the control of the Claims Administrator. The notice will explain the reason for the extension and when the Claims Administrator expects to rule on your claim. If the extension is needed because you failed to provide the information needed to decide the claim, the notice will tell you what additional information you need to furnish. In this event, you will have 45 days from the date you receive the notice to provide the additional information.

CLAIMS DENIAL NOTICE

The notice of the Claims Administrator's claims decisions will be given in writing. If your claim is denied, the notice will include:

- the specific reasons for the denial;
- the specific plan provisions on which the decision is based;
- a description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures, including your right to bring a civil action in court following a claims denial on review;
- a description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge;
- an explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge; and
- for a claims denial involving an urgent care claim, a description of the expedited review process applicable to such claims.

If you have any questions about a denied claim, you should contact the Claims Administrator.

APPEALING A DENIED CLAIM

You (or your authorized representative) will have 180 days after receiving notice that your claim is denied (in whole or in part) to appeal the decision in writing to the Plan Administrator or Claims Administrator (as applicable), unless the review relates to a rescission of coverage, in which case you (or your authorized representative) must submit the request for review within 30 days. You may submit written comments, documents, records, and other information relevant to the claim and will be given the opportunity to present evidence and testimony, if you so choose. In addition, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim (including, without limitation, the claim file).

The Plan Administrator or Claims Administrator (as applicable) shall provide you, as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to

allow you time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

Your appeal will be reviewed by a plan fiduciary that had no role in the initial claim denial and the review will be an independent one without giving the original denial any special consideration. If a medical judgment is involved, the person reviewing your appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who had no role in the initial claim denial. Upon request, the medical or vocational experts whose advice was obtained will be identified.

If your claim relates to Medical, Dental and/or Vision Benefits, you must submit your appeal to the applicable Claims Administrator. With regard to Prescription Drug Benefits, if your claim relates to Medical Necessity, your diagnosis, or the prior authorization of an item under the Prescription Drug Benefits, you must submit your appeal to the Prescription Drug Benefits Claims Administrator. If your claim relates to anything other than Medical Necessity, your diagnosis, or the prior authorization of an item under the Prescription Drug Benefit, you must submit your appeal to the Plan Administrator.

Urgent Care Claims

In case of urgent care, there is an expedited review process where you can call or write the Claims Administrator and where all necessary information regarding the review will be provided to you promptly. You will be notified of the decision on your appeal as soon as possible, taking into account medical requirements, but no later than 72 hours after the plan receives your request for review.

Pre-Service Claims

You will be notified of the decision on your appeal within a reasonable period that is appropriate for your medical condition, but no later than 30 days after the Claims Administrator receives your request for review. However, if the pre-service claim relates to Medical Necessity, your diagnosis or the prior authorization of an item under the Prescription Drug Benefits, you will be notified within 15 days.

Post-Service Claims

You will be notified of the decision on your appeal within 60 days after the Claims Administrator receives your request for review. However, if the post-service claim relates to Medical Necessity, your diagnosis, or the prior authorization of an item under the Prescription Drug Benefits, you will be notified within 30 days.

For any type of claim, before the Plan Administrator or Claims Administrator issues a final denial of your appeal based on a new or additional rationale, you must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow you time to respond. If the Plan Administrator or Claims Administrator determines that there is not a reasonable amount of time for you to respond to the new rationale before the deadline for the final determination on appeal, then the deadline for providing you with the final determination will be extended. The extension will be communicated to you by the Plan Administrator or Claims Administrator and will provide you a reasonable period of time to respond.

If your appeal is denied, you will be notified electronically or in writing. Such notice will include the following:

- the specific reasons for the denial, including a description of the Plan's standard, if any, that was used in denying the claim;
- the specific plan provisions on which the decision was based;

- information sufficient to allow you to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable);
- the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning or a statement that such codes and meanings are available upon request;
- your right to request access to or copies of all information relevant to your claim;
- your right to bring a civil action in court;
- a description of any specific internal rules, guidelines, protocols, or other similar criteria that were relied on in making the decision, OR a statement that the decision was based on the applicable items mentioned above, and copies of the applicable material will be provided upon request, free of charge;
- an explanation of the scientific or clinical judgment used in the decision in the case of decisions regarding Medical Necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge; and
- information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

You and the Plan may also have the right to other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Note that if your claim relates to Medical Necessity, your diagnosis, or the prior authorization of an item under the Prescription Drug Benefits, there is a two-level appeal process, and you must submit your appeals to the Prescription Drug Benefits Claims Administrator before you can proceed with external review (unless expedited external review applies to your claim). Your second level appeal will be reviewed in accordance with the procedures for “Appealing a Denied Claim.”

External Review Process for Specified Benefits

If your appeal of a claim benefit determination is denied, you may be entitled to request and receive an external review by an independent review organization (“IRO”) if your claim involves Medical Benefits or Prescription Drug Benefits.

To be eligible for external review, the following conditions must apply:

(1) You must submit the request for external review in writing to the Claims Administrator within 125 days after you receive notice of the denial of your appeal. External review requests submitted more than 125 days after you receive notice of denial of your appeal will be denied for lack of timely submission; and
(2) You must have been eligible for coverage under the Plan at the time the services in question were or will be provided*;* and
(3) The denial of your claim must not be based on your failure to meet the Plan's eligibility requirements; and
(4) You must have completed the appeals process set forth under the Plan; and
(5) You must have provided all information or forms required by the Plan or its Claims Administrator to process an external review request; and
(6) The denial of the claim must be based on a medical judgment, which may include but is not limited to questions of Medical Necessity, medical appropriateness or safety of treatment or care, appropriateness of health care setting, or medical effectiveness of a treatment, service or covered benefit.

Upon submission to the Claims Administrator of your written request for external review, the Claims Administrator may take up to five business days following receipt of the request to review the request and determine whether the conditions outlined above are met. Within one business day after completion of this preliminary review, the Claims Administrator will provide your written notification of whether your external review request satisfies the conditions for external review, including a description of any additional information or materials necessary to complete the external review request.

If the Claims Administrator notifies you that your request is not complete, you will have 48 hours or until the last day of the 125-day filing period, whichever is later, to submit the additional information.

If your request satisfies the conditions for external review, the Claims Administrator will refer the request to an IRO. The IRO will then be responsible for notifying you, in writing, that the request for external review has been accepted. The IRO's notice should include a statement that you may submit in writing, within 10 business days, any additional information that you wish the IRO to consider when conducting the review. The IRO will share this information with the Plan and the Claims Administrator. The Claims Administrator, acting as the delegate of the Plan Administrator, may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the external review process will end.

If the Claims Administrator does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) Your medical records as available and relevant;
(2) The attending health care professional's recommendation;
(3) Reports from appropriate health care professionals and other documents submitted by you, by the Plan, by the Claims Administrator or by your treating provider;
(4) The terms of the Plan;
(5) Appropriate practice guidelines;
(6) Any applicable clinical review criteria developed and used by the Plan; and
(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to you and the Plan of its final decision within 45 days after the IRO receives your request for the external review. The IRO's decision notice should contain:

(1) A general description of the reason for the external review, including information sufficient to identify the claim;
(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
(3) References to the evidence or documentation the IRO considered in reaching its decision;
(4) A discussion of the principal reason(s) for the IRO's decision;
(5) A statement that the determination is binding and that judicial review may be available to you; and
(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under federal law.

Expedited External Review for Specified Benefits

Generally, as noted above, you must first complete the Plan's appeals process before you can request and receive an external review of a claim denial involving Medical Benefits or Prescription Drug Benefits. However, in some cases the Plan provides for an expedited external review of a claim denial if:

(1) You submit a written request to the Claims Administrator specifically requesting expedited external review; and
(2) The time required to complete the Plan's expedited appeals process would seriously jeopardize your life or health or ability to regain maximum function; or
(3) The time to complete the Plan's standard external review process would seriously jeopardize your life or health or ability to regain maximum function, or if the claim denial in dispute concerns a hospital 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.

Immediately upon receipt of a request for expedited external review, the Claims Administrator will undertake to determine and notify you whether the request satisfies the requirements for expedited external review, including the conditions for external review listed above. If the request qualifies for expedited external review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO received your request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both you and the Claims Administrator.

Authorized Representative Designation

As referenced elsewhere in this summary plan description, you are entitled to designate someone else to act on your behalf as your "authorized representative" to either file a claim for you for Plan benefits, or to pursue an appeal for you whenever your claim for Plan benefits has been denied. For example, you may designate your health care provider who filed a claim on your behalf to also serve as your "authorized representative" to present any appeal on your behalf if the claim is denied.

However, the Claims Administrator for Medical Benefits will recognize an "authorized representative" only if you follow the Claims Administrator's required process for designating such a representative. To properly designate an "authorized representative," the Claims Administrator of Medical Benefits requires that you and your desired "authorized representative" take the following steps: (a) you and your "authorized representative" must fill out and sign the Plan's approved "authorized representative" designation form (the form can be obtained from the Claims Administrator, upon your request); and (b) you or your "authorized representative" must return the fully-completed form, signed by both of you, to the Claims Administrator. In the event of your mental or physical incapacity to complete an "authorized representative" designation form, the Plan will accept signature on your behalf by your legal spouse, civil or domestic partner, or guardian, or if you have no legal spouse, civil or domestic partner, or guardian, then by your next-of-kin or the designated executor of your will, provided the Plan or its Claims Administrator is satisfied that satisfactory proof of such status exists. The Plan does not accept a health care provider's "assignment of benefits" forms as an "authorized representative" designation. Except to the extent mandated by U.S. Department of Labor claims rules in the case of treating health care professionals and urgent care claims, the Plan does not permit appeals on your behalf by any other person or entity not properly designated as your "authorized representative" in the manner specified in this paragraph.

The applicable Claims Administrator for Plan benefits other than Medical Benefits may have different processes for designating an "authorized representative." You should contact the applicable Claims Administrator to make sure that you follow the correct process.

D. Erroneous Claim Payments

Benefits are occasionally paid erroneously by the Plan (i.e., paid more than once or incorrectly under the Plan's terms, conditions, limitations or exclusions). A covered person or provider benefiting from or receiving such an overpayment or erroneous payment shall, upon discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. The Plan has an equitable

lien and/or constructive trust on any such overpayment or incorrect payment. The Plan shall have no obligation to secure other reimbursement of the erroneous payment or overpayment prior to refund by the provider or covered person. The Plan shall have the exclusive right to choose who will repay it for an overpayment or erroneous payment (i.e., including but not limited to the covered person, provider, another plan or insurer). If the Plan elects to seek refund from a covered person, recovery of the erroneous or overpaid amount may, at the Plan's option, be demanded from the covered person or deducted from future claims incurred from the same provider presented for processing.

Providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit claims for reimbursement in strict accord with their state's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator. Any submitted claims not in accordance with the above shall be repaid to the Plan within 30 days of discovery or demand.

The Plan shall be entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

E. Timely Filing of Claims and Appeals and Limitation on Pursuing Legal Action

To be timely, a claim must be received by the Claims Administrator within one year after the date the covered service was rendered. A claim that is not timely filed will be denied. To be timely, any appeal of a claim denial must be filed with the Plan Administrator or Claims Administrator (as applicable) within 180 days after you receive notice that your claim is denied (in whole or in part), unless the review relates to a rescission of coverage, in which case you (or your authorized representative) must submit the appeal within 30 days after you receive notice of any rescission of coverage. If you do not file an appeal of a claim denial in a timely manner in accordance with these Claims Provisions, you will lose the right to appeal the denial and may forfeit the right to file suit in court.

Additionally, if you do not completely follow the internal claims and appeal process described above for your claim, you will forfeit any and all rights you may have had to benefits under the Plan that are the subject of your claim. Generally, you must exhaust (i.e. complete) the internal claims and appeal process described above before you can bring any legal action for benefits under the Plan (such as a lawsuit under Section 502(a) of ERISA).

Under certain circumstances, you may be "deemed" to have exhausted the internal claims and appeal process (i.e., treated as if you completed it). In those cases, you are allowed to bring immediate legal action or proceed immediately to external review. Specifically, if the Plan Administrator or Claims Administrator, as applicable, does not follow the above internal claims and appeal process, then you generally will be deemed to have exhausted the internal claims and appeal process. However, there are exceptions. For example, you will not be allowed to bring immediate legal action or proceed immediately to external review if the failure follow internal claims and appeal process is small, it does not cause, and is not likely to cause, prejudice or harm to you, and it is due to circumstances beyond the control of the Plan Administrator or Claims Administrator, as applicable. You can request a written explanation of the failure from the Plan Administrator or Claims Administrator, as applicable. The Plan Administrator or Claims Administrator, as applicable, will provide that explanation within 10 days of your request. It will include a specific description of the reasons, if any, that the failure does not give you the right to bring immediate legal action or immediately go to external review. If a court or external reviewer rejects your request for immediate review because you failed to exhaust the internal claims and appeal process, then you have the right to resubmit your claim to the Plan Administrator or Claims Administrator, as applicable. If that happens, then no later than 10 days after the court or external reviewer rejects your request, the Plan Administrator or Claims Administrator, as applicable, will provide you with a notice of the opportunity

to resubmit and pursue the internal review of your claim. The applicable time periods for refiling your claim or appeal will start when you receive the notice.

You should also know that there is a time limit for bringing a legal action. Specifically, you cannot bring any legal action for benefits under the Plan more than one (1) year after the denial of your claim on appeal (or deemed exhaustion of the internal review procedure). This limit applies whether you choose to go to external review or not. If you do not bring legal action before the one (1) year period ends, then you will forfeit any right you had or may have had to the benefits that were the subject of your claim. Additionally, you will lose your right to bring legal action for those benefits, regardless of whether all comments, documents, records, or other information relating to the claim were submitted or considered when the initial claim or appeal was decided.

F. Right to Exchange Information

By accepting coverage under the Plan, you agree that:

- the Plan Administrator and its agents may obtain from any provider and may provide to any person or organization (including internal and external review and quality assurance bodies and individuals) all information (including medical records) about you when the information is reasonably necessary to administer the Plan (including grievances and appeals, claims payments, utilization review, case management, quality assurance, subrogation and coordination of benefits, and other functions of Plan administration) and;
- you will provide, upon request, the Plan Administrator or its agents with information you have or control and will provide the additional authorization or direction to any person, institution or organization having medical information about you to furnish the Plan Administrator or its agents with any and all information and records or copies of records relating to you.

By accepting coverage under the Plan, you also will be deemed to have authorized the collection and the release of the information and to have given up any claim of privilege or confidentiality with respect to the information when obtained or released solely for the purposes described above.

SECTION XI. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

A. Summary Plan Description Information

1. The name of the Plan is:

   Tyson Foods, Inc. Group Health Plan

2. The Plan Sponsor's address is:

   2200 West Don Tyson Parkway, Springdale, Arkansas 72762

   Affiliates of the Plan Sponsor may also adopt the Plan for their eligible employees with the approval of the Plan Sponsor.

3.

Employer Identification Number (EIN)	Plan Number
71-0225165	501

4. Plan Type

   With respect to the coverage in this booklet, a group health plan.

5. Type of Administration

   The Plan Administrator has the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Plan Administrator may allocate or delegate its responsibilities for the administration of the Plan by contract to others and employ others to carry out or give advice with respect to its responsibilities under the Plan.

6. The name, address, ZIP code and business telephone number of the Plan Administrator is:

   TYSON FOODS, INC., 2200 West Don Tyson Parkway, Springdale, Arkansas 72762, (855) 328-5291.

7. The name, address and ZIP code of the agent for the service of legal process is:

   TYSON FOODS, INC., 2200 West Don Tyson Parkway, Springdale, Arkansas 72762, (855) 328-5291, c/o General Counsel.

   Service of legal process may also be made upon the Plan Administrator.

8. Plan Year

   The fiscal records of the Plan are maintained on the basis of the Plan Year, which is each twelve-month period ending on December 31st.

9. Plan Modification, Amendment and Termination

   The Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of one or more classes or subclasses of Employees and other persons to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. The Plan Sponsor, by action of its Board of

Directors or any officer, may effect any of these actions. No consent of any covered person is required to terminate, modify, amend or change the Plan.

10. Discretionary Authority

The Plan Administrator has the discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the Plan and the exercise of that discretion is final and binding upon all parties. The Plan Administrator delegates to the Claims Administrator its discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of claims under the Plan. Such discretionary authority is intended to include, but not limited to, the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to the Claims Administrator the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative. The Plan Administrator expressly retains the discretionary authority to determine the eligibility of persons to enroll in or claim eligibility for participation in the Plan and the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative based upon such a claim.

11. Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements. A copy is available from the Plan Administrator upon written request and is available for examination.

12. Funding

With respect to the benefits under this booklet, the Plan is unfunded, which means benefits are paid from the general assets of the Plan Sponsor and adopting affiliates, including contributions from covered persons. Contributions from covered persons are generally determined annually and are established based upon past claims experience, the projection of future health care costs and other related factors, including the Plan Sponsor's determination that adopting employers and covered persons will each bear a portion of the cost of coverage.

13. As a covered Employee in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered Employees shall be entitled to:

a. Receive Information About Your Plan 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 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 Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each covered Employee with a copy of this summary annual report.

b. Continue Group Health Plan Coverage

- continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage, if any, for pre-existing conditions, if you have creditable coverage. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

c. Prudent Actions by Plan Fiduciaries

In addition to creating rights for covered Employees, ERISA imposes duties upon the people responsible for the operation of the 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 covered Employees and beneficiaries. No one, including your employer, your union, 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. 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.

d. Enforce Your Rights

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.

e. 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 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.

SECTION XII. COBRA CONTINUATION OF COVERAGE REQUIREMENTS

A. Introduction

This Section of the Plan describes important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options outside the Plan that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You are responsible for the applicable cost of these options, just as you would be for COBRA coverage.

B. What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this Section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event (Please refer to the eligibility provisions of the Plan to determine whether any of the events listed below will result in a loss of coverage under the Plan). Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "Dependent child."

C. When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the employer must notify the Plan Administrator of the qualifying event.

D. You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the Employee and spouse, or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator by contacting your Benefits representative. If the Plan Administrator is not so notified, the individual will not be given the opportunity to elect COBRA continuation coverage.

E. How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Notice by the Plan Administrator or its agent of the right to elect COBRA continuation coverage sent to you or your spouse will be deemed to be notice to any Dependent child residing with that parent. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their Dependent children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, your divorce, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator or its agent in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order for this additional 11 months to be available, you or a member of your family must provide the Plan Administrator or its agent with notice

of the determination by the Social Security Administration within 60 days of that determination. Such notice must be submitted by you in writing along with a copy of the determination letter from the Social Security Administration to Tyson Foods, Inc. COBRA Administration, Dept. CP501B, P.O. Box 2020, Springdale, AR 72765.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Employee or former Employee dies, or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred. Such notice must be submitted by you in writing to Tyson Foods, Inc. COBRA Administration, Dept. CP501B, P.O. Box 2020, Springdale, AR 72765 within sixty (60) days of the event, but within the 18 months of COBRA continuation coverage.

F. Paying for COBRA Coverage

A qualified beneficiary will be required to pay a premium for COBRA continuation coverage. If the COBRA continuation coverage is elected, all premiums are payable monthly in advance and are due on the first day of the calendar month. There is a 30-day grace period to pay premiums; however, a qualified beneficiary has no less than 45 days from the initial election to pay any monthly premiums otherwise due by the end of the 45-day period. If the premiums payable are not paid before the expiration of the grace period, COBRA continuation coverage will end.

G. When Does COBRA Continuation Coverage End?

COBRA continuation coverage will expire no later than at the end of the applicable maximum period described above; however, certain events will cause COBRA continuation coverage to end prior to the applicable maximum period:

- The date the employer ceases to provide any group health plan.
- The end of the grace period during which the Employee or eligible Dependent fails to make any required premium payment.
- The first day after the date of election on which the Employee or eligible Dependent becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person or the date such exclusions or limitations no longer apply to the Employee or Dependent.
- The date the Employee or eligible Dependent first becomes entitled to Medicare after the date of an election for COBRA continuation coverage.
- With respect to a disabled Employee or Dependent whose coverage is being extended for an additional 11 months because of a disability determination by the Social Security Administration, coverage will terminate on the first day of the month that is 30 days after the date on which the individual is no longer disabled for Social Security purposes.

H. Other Coverage or Continuation Opportunities

Instead of enrolling in COBRA continuation coverage, there may be other coverage options outside the Plan for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage from the Plan. You can learn more about many of these options at www.healthcare.gov.

I. Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

IMPORTANT NOTICE
COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE PLAN.

SECTION XIII. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QMCSO is a type of court or state agency order (including a National Medical Support Notice), usually issued as part of a settlement agreement or divorce decree, that provides for child support or health care coverage for an eligible child of a covered Employee. The court order must:

1. create or recognize the existence of, the child's right, or assigns to the child the right, to receive benefits for which the covered Employee is eligible under the Plan;

2. clearly specify the name and last known mailing address of the covered Employee and the name and mailing address of each child covered by the order, or in lieu of the child's name and address, the name and address of an appropriate state official;

3. specify a reasonable description of the type of coverage to be provided by the Plan to each child or the manner in which the type of coverage is to be determined; and

4. specify the period to which the order applies.

The order may not require a Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

The term "Alternate Recipient" means any eligible child of a covered Employee who is recognized under a medical child support order as having a right to enrollment under a group health plan.

When the Plan Administrator receives a medical child support order, the following steps must be taken:

1. notify both the covered Employee and each Alternate Recipient of the receipt of the order;

2. furnish an explanation of the Plan's procedures for determining whether the order is a QMCSO;

3. determine if it is qualified; and

4. notify the covered Employee and each Alternate Recipient of the determination.

The Plan Administrator is responsible for deciding if the order satisfies the conditions of a QMCSO. If it does, the child is an Alternate Recipient and is considered a beneficiary under the Plan for purposes of any provision of ERISA.

A copy of the Plan's QMCSO procedures is available from the Plan Administrator without charge.

SECTION XIV. LIMITED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and with respect to benefits to which HIPAA applies, the Plan Sponsor:

(a) will not use or further disclose protected health information, except as permitted or required by the Plan document and the Plan's HIPAA Policies and Procedures, as amended, or as required by law;
(b) will not use or disclose protected health information for any employment-related action or decision, or in connection with any other of the Plan Sponsor's employee welfare benefit plans and will restrict access to and use of such information to those employees of the Plan Sponsor and other person specified in the HIPAA Policies and Procedures;
(c) will ensure that any agent to whom the Plan Sponsor provides protected health information agrees to the restrictions and conditions of the Plan document and HIPAA Policies and Procedures, as amended, and such other restrictions as apply to such agent under HIPAA, with respect to protected health information;
(d) will report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures allowed by the Plan document and HIPAA Policies and Procedures, as amended;
(e) will make protected health information available to each covered person who is the subject of the information in accordance with HIPAA;
(f) will make protected health information available for amendment and, on notice from the Plan, amend a covered person's protected health information in accordance with HIPAA;
(g) will track disclosures of protected health information that are not excepted from disclosure accounting as described by the Plan Sponsor's HIPAA Policies and Procedures so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with HIPAA;
(h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA;
(i) if feasible, consistent with applicable record retention requirements, will return or destroy all protected health information that the Plan Sponsor created or received for or from the Plan when the Plan Sponsor no longer needs protected health information for the plan administration functions for which disclosure was made and if such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
(j) Ensure that adequate separation between the Plan and the Plan Sponsor is established as follows:
    (1) Such employees, or classes of employees, or other persons under the control of the Plan Sponsor as discussed in the Plan's HIPAA Policies and Procedures, shall be given access to the protected health information to be disclosed.
    (2) The access to and use of protected health information by the individuals described in Subsection (1) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
    (3) In the event any of the individuals described in Subsection (1) above do not comply with the provisions of the Plan documents relating to use and disclosure of protected health information, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. Such sanctions shall be imposed in accordance with the Plan Sponsor's current policy violation sanctions.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan, or to solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans;

(k) The Plan shall disclose protected health information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that: (1) the Plan documents have been amended to incorporate the above provisions, and (2) the Plan Sponsor agrees to comply with such provisions;
(l) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;
(m) Ensure that the adequate separation between the Plan and the Plan Sponsor is supported by reasonable and appropriate security measures;
(n) Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the electronic information; and
(o) Report to the Plan any Security Incident of which it becomes aware. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Notwithstanding the foregoing, HIPAA contemplates that the Plan may disclose protected health information to health care providers and business associates of the Plan in the course of treatment, payment and other health care operations of the Plan. Protected health information also may be disclosed in more limited circumstances as permitted by HIPAA and rules and regulations issued by those federal agencies responsible for the administration and enforcement of HIPAA.

The employees of the Plan Sponsor and other persons who may have access to protected health information, the restrictions on their access, and the mechanism to resolve any issues of noncompliance, will be embodied in the Plan's HIPAA Policies and Procedures.

The information the Plan Sponsor will return or destroy includes all protected health information in whatever form or medium (including any electronic medium), and all copies of and any data or compilations derived from such information that allow identification of any covered person who is a subject of the information. If it is not feasible to destroy all protected health information, the Plan Sponsor will limit the use or disclosure of any covered person's protected health information it cannot feasibly destroy to those purposes that make the destruction of the information infeasible.

Any issues of noncompliance with HIPAA should be addressed to the Privacy Officer, c/o Tyson Foods, Inc. Group Health Plan, 2200 West Don Tyson Parkway, Springdale, AR 72762.